DEPT.- 65

JOB- 21

REEL- 40

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

KP 79037

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE: Certificate of Death

2. Form No. if available

3. Type—(cards, paper, etc.) Bound Book

4. Dates

5. Volume accumulated yearly

6. Size of Record: Misc.

7. Number of copies made: One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period

a. In Dept. 12 yrs.

b. In Storage Center: Micro. Perm.

c. Total 12 yrs. and Micro. Perm.

10. Equipment and space freed.

11. In your opinion does this record have any historical significance?

YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period

a. In Dept. 12 yrs.

b. In Storage Center: Microfilm Permanent

c. Total 12 yrs. and Microfilm Permanent

14. Disposal Method

A. [ ] To be sold as scrap or waste paper

B. ☒ To be Burned or shredded

C. ☐ Historical, (to be transferred to Dept of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force
Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

KF 23907

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51019

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 E. Preston St.; 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent A. Rosenberger

(Residence in Baltimore: No. 1928 E. Preston St. St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

3-DATE OF BIRTH. May (Month) 7 (Day), 1918 (Year)

7-AGE. 2 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John G. Rosenberger

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Mary Kostohryz

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John G. Rosenberger

(Address) 1928 E. Preston St.

15-

Filed Feb 18 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb 17 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 10 1921, to Feb 17 1921, that I saw h alive on Feb 1921, and that death occurred, on the date stated above, at 9:38 a.m.

The CAUSE OF DEATH* was as follows:

Acute pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) F. Ford Kyzer M. D.

Feb, 1921 (Address) 2001 N. Bolton Pk 446

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Holy Redeemer DATE OF BURIAL, Feb 19, 1921.

20-UNDERTAKER Frank J. Fink ADDRESS 910 N. Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51020

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lemuel Tascoe

(a) RESIDENCE. No. 1013 Booth St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): West River, Maryland.

PARENTS

10 NAME OF FATHER: Scott Tascoe.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Betsy Gant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records.
(Address): New City Hospital.

15 Filed: Robert P. Harrison, Registrar

FEB 19 192

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 17, 19 21

17 I HEREBY CERTIFY, That I attended deceased from October 8, 19 20, to February 17, 19 21 that I last saw h im alive on February 16, 19 21. and that death occurred, on the date stated above, at 9:10 A. m.

The CAUSE OF DEATH* was as follows:

Arterio — sclerosis. (No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) Hutzman. M. D.

2/17/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Feb 24 192
20 UNDERTAKER: Joseph A Farrell	ADDRESS: 2317 Druid

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51021

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Hasley St.: 21 WARD)

2-FULL NAME Mary Edwards

(a) RESIDENCE. NO. 1303 Hasley St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): May 10 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 600

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Henry Schmelz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Mallie

(Address): Boston Ky St

15 Filed FEB 19 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/17 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Feb 17, 1921, that I last saw h alive on Feb 17, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary): Hemiplegia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Stephen Wann, M. D.

(Address) 1111 Columbus.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb 19th 1921
20 UNDERTAKER	ADDRESS
Geo Leimbach & Son	647 W Pratt

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.51022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 W. 36 St ST.; 13 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma F Knott

(Residence in Baltimore: No. 1415 W. 36 St St.; Life yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov (Month) 10 (Day), 1919 (Year)

7-AGE, 1 yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, Byrd Knott

11-BIRTHPLACE OF FATHER (State or Country). Thurmont Md

12-MAIDEN NAME OF MOTHER Lora Lovell

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lora Knott

(Address) 1415 W. 36 St

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk.

Registrar.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B 19921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 11th 1921, to Feb 17 1921, that I saw h alive on Feb 17 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) C. L. Normand M. D.

2-18, 1921. (Address) 334 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mays Franklin DATE OF BURIAL, Feb 19, 1921

20-UNDERTAKER A S Marshall ADDRESS 1339 Fall Rd

(Hustead)

D.51023 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51023

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Poplar & Hickory ave St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Edward Hustead

(Residence in Baltimore: No. Poplar & Hickory ave St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 19 (Day), 1862 (Year)

7-AGE, 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William H. Hustead

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Martha Bacon

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna L. Hustead

(Address) Poplar and Hickory ave

15- Covered Mot

Filed FEB 19 1921, 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

2-18, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Feb. 21, 19 21

20-UNDERTAKER George J. Smith

ADDRESS 1000 Fayette

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 19 1921

Burial Permit Clerk.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51024 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51024

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2937 Mosher ST.; 16 WARD) REGISTERED NO. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Legg

(Residence in Baltimore: No. 2937 Mosher St.; 72 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, June 14, 1845
(Month) (Day) (Year)

7-AGE, 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Walter Ramsen

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Linker

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James D. Legg

(Address) 2937 Mosher St

15-

Filed Feb 19 1921 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 18, 1921.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 14 1921, to Feb 18 1921, that I saw h alive on Feb 17 1921, and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Int Nephritis

Myocarditis (Duration) 2 yrs. 6 mos. ds.

(Signed) Alvin I. Lemmon M. D.

Feb 18, 1921. (Address) 914 N. Patterson Pk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb 21, 1921

20-UNDERTAKER George J. Smith — ADDRESS 1000 Fayett St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51025

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 S 13 Ethel ST.; 2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Borowski

(Residence in Baltimore: No. 706 S Bethel St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	Single

6-DATE OF BIRTH, December 23, 1920.
(Month) (Day) (Year)

7-AGE, ... yrs. 1 mos. 25 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... Nil

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Witold Borowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Josefa Satkowska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Witold Borowski

(Address) 706 S. Bethel St.

15-

Filed FEB 9 1921, 19.. Robert P. Harrison
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 18, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 11 1921, to February 11 1921, that I saw h.. alive on February 18 1921, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

.....
.....
Bronchitis
..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Insanitation
..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) H. L. Leonard M. D.

February 18, 1921. (Address) 222 S. Ann St.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus — DATE OF BURIAL, Feb. 19., 1921.

20-UNDERTAKER John A Weber — ADDRESS 1803 Bank St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

20.51026

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51026

CERTIFICATE OF DEATH.

REGISTERED No. C 11 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 Forest Place ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Albany Rogers

(Residence in Baltimore: No. 1130 Forest Place St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH Aug 11, 1877 (Month) (Day) (Year)

7-AGE, 43 yrs. 6 mos. 6 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Boat-Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Bldg Supplies

9-BIRTHPLACE, (State or Country), India

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert L. Daley.

(Address) 1130 Forest Place.

15- Filed FEBT 9 1921, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 17, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 12 1921, to Feb 17 1921, that I saw h[illegible] alive on 2/16 1921, and that death occurred, on the date stated above, at 8:45 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris 7 hours (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis about (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) Wm C Straith M. D.

2/18, 1921 (Address) 2036 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral	Feb 21 1921
20-UNDERTAKER	ADDRESS
H C Wadsfield	714 Gruner Bldg

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.51027 (Sophia Junery) HEALTH DEPARTMENT—CITY OF BALTIMORE D.51027

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5220 Kenmore ave St.: 27 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Junery

(Residence in Baltimore: No. 5220 Kenmore ave St.; yrs., 6 mos. 6 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F | 4-COLOR OR RACE, C | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) W

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, ... yrs. 7 mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Baby (b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Louis Junery

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Alberta Westergh

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Junery

(Address) 5220 Kenmore Ave

15- Filed Feb 20, 1921 Robert P. Harrison, Registrar.

FEB 19 1921 [Burial Permit Clerk.]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 17, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchitis

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Morrissey M. D.
(Coroner.)

Feb 20, 1921 (Address) 3632 Boulevard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Feb 17, 1921

20-UNDERTAKER Samuel T. Hemsley ADDRESS 5700 Baltimore

Spec.—8-24-14—M. & T.—2000 Blks.

D.51028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51028

CERTIFICATE OF DEATH.

REGISTERED NO. C 10-041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611½ Brunt ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia A. Neal

(Residence in Baltimore: No. 1611½ Brunt St.; 50 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, Aug — —, 1871.
(Month) (Day) (Year)

7-AGE, 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Molneck, W.V.I.

PARENTS.

10-NAME OF FATHER, Wm Mathews

11-BIRTHPLACE OF FATHER (State or Country), W.V.I.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Neal

(Address) 1611½ Brunt St.

15-

Filed FEB 19 1921, 191

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 17, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 14 1900, to Feb. 17 1921, that I saw her alive on Feb. 15 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 7 ds.

(Signed) W. L. Carr M. D.

Feb 19, 1921 (Address) 3 N Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Feb. 1921
20-UNDERTAKER	ADDRESS
Samuel Hendrix	1118 Bdwy

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Maggie L.

D. 51029

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51029

55

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 18 WARD)

2-FULL NAME Maggie L. Kerlinger

(a) RESIDENCE. NO. 1308 W. Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. 12 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4. COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Louis Reed

11 BIRTHPLACE OF FATHER (city or town) Orchestra Leo (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda R. Forney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William McP. Kerlinger (Address) 1308 W. Mulberry St

15 Filed FEB 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17/ 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1920, to Feb. 17, 1921, that I last saw h[e]r alive on Feb. 17th, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration
(Encephalitis — Lethargica)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Encephalitis Lethargica (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Clinical

(Signed) J. H. McP. Clark, M. D.

, 19 (Address) 1312 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Feb 19 1921

20 UNDERTAKER ADDRESS

Chas. G. Black 742 W. North ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. OCCUPATION should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.51030 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51030

CERTIFICATE OF DEATH. 3 + 169 V

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Foot of Carolina St. 3 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles White

(Residence in Baltimore: No. Sparrows Point Unknown St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	colored	single

6-DATE OF BIRTH, Unknown ....., 190? (Month) (Day) (Year)

7-AGE, 18 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....ds.

2/16/21 (Signed) Chas. Sam Kuehl (Coroner.) M. D.

..... 191... (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	2-19, 1921
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2 19 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51031

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Payne

(a) RESIDENCE. No. 1447 Ward st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

67

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Payne

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed FEB 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17, 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1921, to Feb. 17, 1921,

that I last saw her alive on Feb. 17, 1921,

and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. S. Fahndrich, M. D.

2-17-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL FEB 1 1921

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Commissioner Health,

Per. Wm. E. WOODALL

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51032 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51032

CERTIFICATE OF DEATH.

REGISTERED NO. 10740

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1040 Brentwood Ave ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Maloney.

(a) RESIDENCE. NO. 1040 Brentwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., If of foreign birth? 38 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (HW)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER William Maloney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Bolger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Anastatia Doyle
(Address) 1040 Brentwood Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

FEB 19 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1920, to Feb 18, 1921, that I last saw her alive on Feb 18, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray reports

(Signed) J. F. W. Oltemeth, M. D.

Feb 19, 1921 (Address) 1310 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Feb 21 1921

20 UNDERTAKER Henry Hoeck Son

ADDRESS 1501 E Eager St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51033 ✓20.51033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5319 Dunmore Av ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Maria Morgan

(a) RESIDENCE. No. 5319 Dunmore Av St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of Frank Morgan

6 DATE OF BIRTH (month, day, and year) May 31/1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Helwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Frank Morgan (Address) 5319 Dunmore Av

15 Filed Feb 9 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1921, to Feby 17, 1921, that I last saw her alive on Feby 16 1921, and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Consumption, tuberculosis of lungs

about 3 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Grad Marasmus (duration) 2 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Anamnesis

(Signed) E. Kanik, M. D.

2/17, 1921 (Address) 1605 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	2-19 1921
20 UNDERTAKER	ADDRESS
Wm Chas A J Robb	600 W Arlington Ave

I. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.51034 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 216 S. High St. St.: 3 WARD) 79

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Cochran

(Residence in Baltimore: No. 216 S. High St. St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1885 (Year)

7-AGE,	If LESS than 1 day,
35 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), 1

12-MAIDEN NAME OF MOTHER 1

13-BIRTHPLACE OF MOTHER (State or Country), 1

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lours

(Address) 1411 E Balto St

15-

Robert P. Harrison,

Filed ....., 191.....

Registrar.

Burial Permit Clerk.

FEB 19 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~Feb~~ ..... (Month) 17 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Edward Gill Emrich M. D.
(Coroner.)

..... 191... (Address) 1 North Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel	Feb 21, 1921
20-UNDERTAKER	ADDRESS
Jack Lours	1411 E Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.51035 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51035

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1519 Prestman ST. 15 WARD) REGISTERED No. C. 104

2-FULL NAME Earl Dobson

(Residence in Baltimore: No. 1519 Prestman St.; yrs., 2 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
male	colored	single

6-DATE OF BIRTH, Dec 16, 1919 (Month) (Day) (Year)

7-AGE, 2 yrs. 2 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltic Md

PARENTS.

10-NAME OF FATHER, Frank Spriggs

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lillie Harrison

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Dennis

(Address) 1503 Prestman

15- Robert P. Harrison, Registrar.

Filed FEB 19 1921, 191.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 17, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) auto history

(Duration) yrs. mos. ds.

(Signed) J. J. Kennedy M. D. (Coroner.)

Feb. 19, 1921 (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Feb 19 1921
20-UNDERTAKER	ADDRESS
JAMES H. DENNIS	1503 PRESTMAN ST.

(Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51036

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3007 Eastern Av ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Wood

(a) RESIDENCE. NO. 3007 Eastern ave ST., 1st WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of David Wood

6 DATE OF BIRTH (month, day, and year) Dec. 24. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward Harp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary E. Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant David Wood

(Address) 3007 Eastern ave.

15 Filed FEB 19 1921 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1921 to Feb 18, 1921 that I last saw h alive on Feb 18, 1921 and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage 6d

(duration) yrs. mos. 6d ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo Deeley M. D.

2-19-21 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Feb 22 1921
20 UNDERTAKER	ADDRESS
Burkler & Fickler	1739 Eager

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Pks.

D. 51037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51037

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton G. Himmelman

(a) RESIDENCE. NO. 3812 Foster Ave. WARD. 7

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Fred W. Himmelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Antonia Schaaf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Fred W. Himmelman

(Address) 3812 Foster ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

FEB 19 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febr. 18/ 1921

17 I HEREBY CERTIFY, That I attended deceased from Febr. 18/ 1921 to Febr. 18/ 1921, that I last saw him alive on Febr. 18 — 1921, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Intussusception

..... (duration) yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Toxemia —

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 2/18/21

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathology

(Signed) Philibert Antpenn M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Feb 19 1921
20 UNDERTAKER Gribler & Gribler	ADDRESS 1739 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1051038

HEALTH DEPARTMENT—CITY OF BALTIMORE

1051038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 114 S. Madeira ST.: 1 WARD) REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret C. Spiegel

(a) RESIDENCE. NO. 114 S Madeira ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Valentine Spiegel

6 DATE OF BIRTH (month, day, and year) Aug. 6-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Bossleim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margant Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Barbara Stadter
(Address) 114 S. Madeira St.

15 FEB 20 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1921, to Feb 17, 1921, that I last saw h[illegible] alive on Feb 16, 1921, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm F McAvoy, M. D.

Feb 18 1921 (Address) 829 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Feb. 21 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler.	403 S Wolfe St.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1051039

HEALTH DEPARTMENT—CITY OF BALTIMORE

1051039

CERTIFICATE OF DEATH.

REGISTERED NO. 6041

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1125 E Pratt ST.: 3 WARD)

2-FULL NAME Ivan R Modzzlewski

(a) RESIDENCE. NO. 1125 E Pratt St ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 24 ds. How long in U. S., If of foreign birth? yrs. 11 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feby 24-1920.

7 AGE: Years — Months: 11 — Days: 24 — If LESS than 1 day... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nw

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Wladislaw Modzlewski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Sophia Borkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: Sophia Modzlewski.

(Address): 1125 E. Pratt St.

FEB 20 1921

ROBERT F KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1921, to Feb 19, 1921, that I last saw h— alive on Feb 19, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

1. Bronchopneumonia

duration: yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Measles

duration: yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Kyser M. D.

19 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Grn.

DATE OF BURIAL: Feby 20" 1921.

20 UNDERTAKER: M F. Sadowski

ADDRESS: 905 N. Gmn

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information is required. CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

9 Krzyszczynski S

D 51040

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51040

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S Ann St ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Krzyszczynski

(a) RESIDENCE. No. 523 S Ann St ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wiktor Krzyszczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Bis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Wiktor Krzyszczynski 523 S Ann St

15 DATE RECEIVED FEB 20 1921

ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19 1921

17

I HEREBY CERTIFY, That I attended deceased from 2/14 1921 to 2/19 1921

that I last saw her alive on 2/14 1921

and that death occurred, on the date stated above, at 1430 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Recent fracture

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Ivy D Smileff, M. D.

19 (Address) 1623 E North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 21 1921

20 UNDERTAKER John L Weber ADDRESS 1803 Bank

GIVE PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Pipca

Spec.—6-9-19—H. P. Co.—100 Bks.

2051041 HEALTH DEPARTMENT—CITY OF BALTIMORE 2051041

CERTIFICATE OF DEATH. 40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 S. Ann ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Pipca

(a) RESIDENCE. NO. 404 S. Ann ST., ...WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antor Pipca

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	68			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Antor Pipca (Address) 1048 Cross St

15 Filed FEB 20 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-18 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Feb-17, 1921, that I last saw her alive on Feb. 16, 1921, and that death occurred, on the date stated above, at 11.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. One mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Obj. & subj. symps.

(Signed) C. G. Rusk, M. D.

, 19 (Address) 1301 N. Chas. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 21 1921
20 UNDERTAKER Frank Cracken	ADDRESS 1916 Fulton

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

051042 051042 40

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1647 Barnes ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Baroch

(Residence in Baltimore: No. 934 N Durham St.; -0 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Not Known, 1 ..... (Month) (Day) (Year)

7-AGE, 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Michael Baroch

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Kate Begensky

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Constantine Baroch

(Address) 934 N. Durham St.

15- FEB 20 1921

Filed ....., 191.... ROBERT P. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to Feb 18 1921 that I saw h m alive on Feb 18 1921 and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Cancer Oesophagus

(Duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) ... yrs. ... mos. 1 ... ds.

(Signed) ..... M. D.

2-19 ....., 191.. (Address) 800 N Patterson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Feb 22, 1921

20-UNDERTAKER Fred Brach Son — ADDRESS 1806 Eastland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Berry.

D51043

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D51043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2726-Fenwick ave. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward J. Berry

(Residence in Baltimore: No. 2726-Fenwick ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, June (Month) 16 (Day), 1855 (Year)

7-AGE, 65 yrs. 8 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Silversmith
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Edw. J. Berry

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Fannie Miller

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elda

(Address) 2726 Fenwick

15- Filed FEB 20 1921 ROBERT A. BRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 17th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1921, to Feb. 17, 1921, that I saw him alive on Feb. 17, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Empyema

(Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

2/20, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, 2/22, 1921.

20-UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51044

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Service Hosp. #56 REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.; 7-28 WARD) 35

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lewis

(a) RESIDENCE. No. Fort McHenry Baltimore Md. US Public Health Service Hosp. #56
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23 yrs.	---	-----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) -------

(c) Name of employer ----------

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Lewis

11 BIRTHPLACE OF FATHER (city or town) Unknwon
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Edgar T Brenaman Registrar

Informant (Address) Fort McHenry Baltimore Md.

15 FEB 20 1921 ROBERT E KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1921

17 I HEREBY CERTIFY, That I attended deceased from February 3, 1921, to February 19 21

that I last saw him alive on February 19, 1921.

and that death occurred, on the date stated above, at 3'30 A.M

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ----

Was there an autopsy? No

What test confirmed diagnosis? Exam. Laboratory report

(Signed) J. W. Richards P.A Surgeon U. S. D.

, 19 (Address) US. Public Health Hosp. #56

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Lehren Rosedale — DATE OF BURIAL 2/20 1921

20 UNDERTAKER Jack Lewis — ADDRESS 1411 E Balt

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Buel

951045

Spec.—6-9-19—H. P. Co.—1000 Bks.

951045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2418 Barclay ST. 12 WARD)

2-FULL NAME Bessie I Buel

(a) RESIDENCE. No. 2418 Barclay ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Daughter of Wm Buel & Isabella Buel

6 DATE OF BIRTH (month, day, and year) Jan 26 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	0	33	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm M Buel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Isabella J Turpaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Wm M Buel 2418 Barclay St

15 Filed FEB 20 1921 ROBERT S. GRAETER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 18 1921

17

I HEREBY CERTIFY, That I attended deceased from March, 1920, to Feb 18, 1921, that I last saw her alive on Feb 18 1921, and that death occurred, on the date stated above, at 2 35 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver & Left lung

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 1st.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. T. Gabriel, M. D.

19 (Address) 2413 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Feby 21 1921
20 UNDERTAKER	ADDRESS
Wm Cade & Son	502 E Baltimore

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

051046 HEALTH DEPARTMENT—CITY OF BALTIMORE 051046

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1713 Barnes ST. 7 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodosia Biggby

(Residence in Baltimore: No. (Chester Pa) St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 32 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Laborer

9-BIRTHPLACE, (State or Country), Lives Baltimore / Says Georgia.

PARENTS.

10-NAME OF FATHER, John Bigby

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Single name Unknown Nellie Bigby

13-BIRTHPLACE OF MOTHER (State or Country), Ga.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Tilly Bigby

(Address) 1713 Barnes St

15 FEB 20 1921 ROBERT I KRAUTER

Filed ....., 191.... Assistant Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb. 18 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner)

2-15-, 192.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence (Chester Pa.)

19-PLACE OF BURIAL OR REMOVAL, Atlanta Ga

DATE OF BURIAL, Feb 20 19.21

20-UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D51047 HEALTH DEPARTMENT--CITY OF BALTIMORE D51047

CERTIFICATE OF DEATH

10-42

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No 1446 Decatur W St. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Weinmann

(Residence in Baltimore: No. 1446 Decatur St.; 35 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: July 8, 1856 (Month) (Day) (Year)

7-AGE: 64 yrs. 7 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work: Housework. (b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE (State or country): Austria

PARENTS

10-NAME OF FATHER: Not known

11-BIRTHPLACE OF FATHER (State or country): Austria

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER (State or country): Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Weinmann

(Address) 1446 Decatur St

15 FEB 20 1921 Filed ....., 191.

ROBERT F KRAUTER Burial Transit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July 19, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1921, to July 19 1921, that I saw h[er] alive on July 18, 1921, and that death occurred, on the date stated above, at 3 a. m. The CAUSE OF DEATH* was as follows:

Pleuretis

..... (Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. Gustav Dee M. D.

July 19, 1921 (Address) 1433 E Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Cross Cem Co

DATE OF BURIAL: 2-24-1921

20-UNDERTAKER: Edw B Hunter

ADDRESS: 115 E West St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51048 HEALTH DEPARTMENT—CITY OF BALTIMORE D51048

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ken Oak Road, Mt. Washington ST.: 27 WARD) 82

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret McCormick Carroll

(a) RESIDENCE. No. Ken Oak Road, Mt. Washington ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 70 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses F. Carroll

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Lawrence McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Burlong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Joseph B. Kirby

(Address) Ken Oak Road, Mt. Washington

15 Filed FEB 20 1921 Registrar ROBERT J. KRAUSE

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 12th, 1921, to Feby 18th, 1921, that I last saw h[illegible] alive on Feby 18th, 1921, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

(4 hrs 5 hrs)

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Stan Kelly, M. D.

2.19.1921 (Address) 1515 Bond Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery, Govans	2/21 1921
20 UNDERTAKER	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A051049 HEALTH DEPARTMENT—CITY OF BALTIMORE A051049

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1523 W Lexington ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Roberto

(Residence in Baltimore: No. 1523 W Lexington St.; (yrs. 17) mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	Married

6-DATE OF BIRTH, Sept (Month) 26 (Day), 1870 (Year)

7-AGE, 60 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Music teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Ob

9-BIRTHPLACE, (State or Country), France

PARENTS.

10-NAME OF FATHER, Emil Robert

11-BIRTHPLACE OF FATHER (State or Country), France

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emil Robert
(Address) 1523 W Lexington St

15- Filed FEB 20 1921, 191..... ROBERT P KRAUTER Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(Duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemorrhage from lungs (Duration) yrs. mos. 1/1 ds.

(Signed) James W Kent M. D. (Coroner.)
Feb 19 1921 (Address) Fort Cheney

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	2/21, 1921
20-UNDERTAKER Henry W. Mears & Son	ADDRESS 80 N. Calvert St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Coast Guard Rd ST.; Curtis Bay 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. McCarty

(a) RESIDENCE. No. Coast Guard Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? 1 yrs. 2 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 19 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. A. McCarty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary L. Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. C. B. McCarty
(Address) Coast Guard Rd.

15 Filed FEB 20 1921 ROLL REGISTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 6 2, 1921, to Feb 19, 1921, that I last saw h— alive on Feb 19, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. L. Campbell, M. D.

2/20 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooms Isl. Md.	2/21 1921
20 UNDERTAKER	ADDRESS
S. Frew McCully	130 E. Fa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1951051 HEALTH DEPARTMENT—CITY OF BALTIMORE 1951051

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 Dailey ave ST.; 8 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gottlieb H. Kirschner

(Residence in Baltimore: No. 1600 Dailey ave. St.; 37 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 17 (Day) 1851 (Year)

7-AGE, 69 yrs. 9 mos. 4 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Gottlieb H. Kirschner

11-BIRTHPLACE OF FATHER (State or Country), Germy

12-MAIDEN NAME OF MOTHER Julia A. Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Germy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant:) Emma G. Kirschner

(Address) 1600 Dailey ave

15- Filed FEB 20 1921 Robert J. Krafft Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 14 1921, to Feb 18 1921, that I saw h[illegible] alive on Feb. 17 1921, and that death occurred, on the date stated above, at 9:55 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) yrs. mos. ds.

(Signed) G. Lotsta Boalt M. D.

Feb 19, 1921. (Address) 905 N. Fremont St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Feb 21st, 1921.

20-UNDERTAKER E. Schumacher Son ADDRESS 1034 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51052

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 W Fayette St. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Lee Thursby

(a) RESIDENCE. No. 1207 W Fayette St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Operated a tobacco

(b) General nature of industry, business, or establishment in which employed (or employer): Store & coal yard Combined

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Robert H Thursby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Caroline M. Penney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant Mrs Rose Bruce (Address) 1207 W Fayette St

15 Filed FEB 20 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Feb 19, 1921, that I last saw h— alive on Feb 18, 1921, and that death occurred, on the date stated above, at 10.45 m.

The CAUSE OF DEATH* was as follows:

Pericarditis Complicated by a Static Pneumonia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard L Grant M. D.

2/19/1921 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 21 1921
20 UNDERTAKER	ADDRESS
George J Smith	1000 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Bks.

D 51053 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51053

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 N. Charles ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Mouse

(a) RESIDENCE. No. 900 N. Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: P. H. Mouse

6 DATE OF BIRTH (month, day, and year): May 10 1865

7 AGE: Years 55 Months 9 Days 8 If LESS than day, hrs. or min.

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work: None 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Augusta Kerns.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Virginia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: P. H. Mouse (Address) Catonsville Md

15 Filed FEB 21 1921 ROBERT A. KRAUTER Registrar Burial Permit 01564

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 18 1921

17 I HEREBY CERTIFY, That I attended deceased (from Jan 22, 1921 to Feb 18, 1921) that I last saw her alive on Feb 16, 1921, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) J. E. Runnbeck M. D.

2/21/1921 (Address) 1312 Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hancock Md	2/21 1921
20 UNDERTAKER	ADDRESS
Jones & Toulson	12-17 N. Greene St

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51054

HEALTH DEPARTMENT—CITY OF BALTIMORE

51054

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womens Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Anna Douglas Handy

(Residence in Baltimore: No. Woman Hospital St.; ..... yrs., ... mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	widow

6-DATE OF BIRTH, Sept. (Month) 23 (Day), 1847 (Year)

7-AGE,	If LESS than 1 day,
73 yrs. 4 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Dr. Thos. P. Bagwell

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Sallie Hamilton Wise

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth C. H. Valk

(Address) Annapolis Md

15- FEB 21 1921 Filed ..... 191... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 11, 1921, to Feb. 20, 1921, that I saw h er alive on Feb. 20, 1921, and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as followa:

Chronic Nephritis & Uremia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Ureteral Stricture ?

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Neverthwistle M. D.

Feb 21, 1921. (Address) Womens Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State 52 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Annapolis, Md.

19-PLACE OF BURIAL OR REMOVAL: St. Anne's Cemetery Annapolis, Md.

DATE OF BURIAL. Feb. 22, 1921.

20-UNDERTAKER Jas. S. Taylor Sons

ADDRESS Annapolis Md.

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dec.—6-9-19—H. P. Co.—1000 Bks.

D 51055

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51055

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22-621 ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hedderich

(a) RESIDENCE. No. 22-621 ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Hedderich

6 DATE OF BIRTH (month, day, and year) March 4 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Bernard Hedderich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Amelia Hedderich (Address) 22-621 St.

15 Filed FEB 21 1921 [illegible] KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 19 21

17 I HEREBY CERTIFY, That I attended deceased from Feb 12 19 21, to Feb 19 19 21, that I last saw h.. alive on Feb 14 19 21, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Interstinal Stephenosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Wm H Pospe M. D.

19 (Address) 2125 E. Lan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	2/22/21
20 UNDERTAKER	ADDRESS
Wm J Talbert Jr	Belair Rd & Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 51056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51056

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St.: 13 167 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Harrison

(Residence in Baltimore: No. ~~1905~~ 1905 Retreat St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... Aug. (Month) ..... (Day) ....., 1919 (Year)

7-AGE, 1 yrs. 7 mos. — ds. If LESS than 1 day, ...hrs. or ....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... born 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Arthur Kellander

11-BIRTHPLACE OF FATHER (State or Country). Bath Md

12-MAIDEN NAME OF MOTHER Pearl Harrison

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pearl Harrison

(Address) 1504 Retreat St

15- FEB 21 1921 ROBT. F. KRAUTER

Filed ..... 191 ..... Clerk

Burial Permit ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said..... ~~Inquest, au-~~ ..... find that said deceased came to ~~her~~ death ~~topsy or inquiry.)~~ on the day stated above.

The CAUSE OF DEATH* was as follows:

accidentally burned on body

..... (Duration) ..... yrs. A few hrs. mos. ds.

CONTRIBUTORY (Secondary) Explosion World stove

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... B K Grumbine M. D.

(Coroner.)

2-20 1924 (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	Feb 24, 1921
20-UNDERTAKER	ADDRESS
W J Jackson	South Penn

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51057

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1766 Keyser ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph E Dorsey

(a) RESIDENCE. No. 1766 Keyser ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Florence Holbrook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Florence M. Dorsey

(Address) 1766 Keyser St

15 FEB 21 1921 BOARD OF HEALTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 16, 1921, to Feb 18, 1921, that I last saw h[illegible] alive on Feb 16, 1921, and that death occurred, on the date stated above, at 4 30 Am m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Prot Over)

Indefinite (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? V

(Signed) Edward Fisher, M. D

2-16 1921 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Feb 21 1921
20 UNDERTAKER	ADDRESS
J L Brown & Son	1828 Mountg Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D51058

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51058

CERTIFICATE OF DEATH.

18 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 W Lexington ST.; 18 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Jones

(Residence in Baltimore: No. 1111 W Lexington St.: .....yrs., 6 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Married

6-DATE OF BIRTH, June 22, 1901
(Month) (Day) (Year)

7-AGE, 19 yrs. 7 mos. 28 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 033

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Thomas Taylor

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Malinda Ball.

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard H Taylor (Brother)

(Address) R F D #1 Box 62A Richmond Va

15- FEB 21 1921 SCHAEFER & BAUER

Filed ....., 191.... Burial Permit Issued

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1920, to Feb 19th 1921, that I saw h[illegible] alive on Feb 19th 1921, and that death occurred, on the date stated above, at 12.15a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E Emmett Fargo M. D.

Feb 22nd, 1921 (Address) 1146 E Main St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Virginia

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Richmond Va	2/23/21 191...
20-UNDERTAKER	ADDRESS
Mrs Gertrude Hooper	406 N Conway St

Spec.—8-24-14—M. & T.—2000 Bks.

Cohoon.

D 51059

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51059

CERTIFICATE OF DEATH.

REGISTERED NO. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 d. Dietz ST.; Jonestown (WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Arbutus Cohoon

(Residence in Baltimore: No. 208 N Caroll St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb (Month) 24 (Day), 1831 (Year)

7-AGE, 90 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Ireland Cohoon

PARENTS.

10-NAME OF FATHER, John Cohoon

11-BIRTHPLACE OF FATHER (State or Country) Ireland Cohoon

12-MAIDEN NAME OF MOTHER Mc Mann

13-BIRTHPLACE OF MOTHER (State or Country), Northern Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. M. Conner

(Address) 208 N Caroll

15- FEB 21 1921 Filed, 191 ROBERT A KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 20th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 15 1921, to Feb 20th 1921, that I saw h[illegible] alive on Feb 20th 1921, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

History (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Old age yrs. mos. ds.

(Duration)

(Signed) Hugh D Hall M. D.

Feb 21, 1921 (Address) 1203 Light

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Paul's Cem Marion Md — DATE OF BURIAL, 2/22/1921

20-UNDERTAKER W J Swift — ADDRESS 1000 N Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bkr.

Bu

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51060 — 10-09 — D51060

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N. Centre ST. 11 WARD)

2-FULL NAME Bessie McGuire

(a) RESIDENCE. No. 213 N. Centre ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Phillip McGuire

6 DATE OF BIRTH (month, day, and year): Oct 5 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John McGuire

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Minnie McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Ella McGuire
(Address) 213 N. Centre St

15 Filed FEB 21 1921 19 ROBERT A. FEUTH Registrar Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 13, 1921, to Feby 20, 1921, that I last saw h[illegible] alive on Feby 19, 1921, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia 8

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. A. O'Neill M. D.

2/20, 1921 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Feb 22 1921
20 UNDERTAKER	ADDRESS
J. Harry Fields	1200 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51061

CERTIFICATE OF DEATH.

REGISTERED NO. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2732 Hundington ave. WARD) 12

2-FULL NAME David H Harrington

(a) RESIDENCE. No. 2732 Hundington ave. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Nov 24 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER David Harrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) VA

12 MAIDEN NAME OF MOTHER Mary Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 Informant David Harrington
(Address) 2732 Hundington ave

15 Filed FEB 21 1921

16 Registrar's Office

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1921, to Feb. 19, 1921, that I last saw him alive on Feb. 19, 1921, and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Heart Collapse

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 2732 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Feb 21 1921
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D51062

Supt. — 6-9-19 — H. P. Co. — 1000 Bks.

D51062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29-010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 S. First St. Brooklyn Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard S Sharp

(a) RESIDENCE. No. 203 S. First St. Brooklyn Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Marley Anne Co Md

PARENTS

10 NAME OF FATHER John F Sharp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Clara V Scamon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elvaton Anne Co Md

14 Informant (Address) John F Sharp 203 S First St

15 Filed FEB 21 1921 19 ERNEST L KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1921

17

I HEREBY CERTIFY, That I attended deceased from February 6th 1921, to February 20th 1921, that I last saw him alive on February 19th 1921, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Tuberculosis

(duration) — yrs. — mos. 9 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Harry Schleibel M. D.

2/2/ 1921 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mayotthy Church Cemetery	2/22/ 1920
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	718 LIGHT ST.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

BROMWELL

Spec. 6-9-19 H. P. Co.—1000 Bks.

D51063

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51063

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Robt Garrett Hosp

CITY OF BALTIMORE: (No. 27 N. Carey ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy Lee Bromwell

(a) RESIDENCE. NO. Rock Creek, Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs — mos. 18 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 1, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Roy Lee Bromwell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Talbot Co. Md

12 MAIDEN NAME OF MOTHER Grace Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Roy Lee Bromwell
(Address) Residence same

15 Filed FEB 21 1921, 19 WM. J. KRAUTER Registrar

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 18 1921

17

I HEREBY CERTIFY, That I attended deceased from Feby 15, 1921, to Feby 18, 1921, that I last saw h im alive on Feby 17, 1921, and that death occurred, on the date stated above, at 6 00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. Lee Clift, M. D.

2/18, 19 21 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
CEDAR HILL	FEB 21 1921

20 UNDERTAKER JOHN F. DENNY ADDRESS 715 LIGHT ST.

Lydia Snydam

D51064

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51064

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. South Balto Gen. Hospital WARD) 22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lyddia Snydam

(a) RESIDENCE. NO. 110 W. Lee ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Snydam

6 DATE OF BIRTH (month, day, and year) Mar. 9. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Brunswick N. J.

PARENTS

10 NAME OF FATHER — Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER — Quackenbush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant (Address) South Balto Gen. Hospital 1243 Light St.

15 Filed FEB 21 1921 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-9, 1921, to 2-21, 1921, that I last saw her alive on 2-21, 1921, and that death occurred, on the date stated above, at 1.35 p.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia.

over

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Abscess of lung.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard L. Dixon M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Brunswick N.J.	Feb 23 1921
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Abscess due to pneumonia.
No tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51065

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51065

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 McDermott Ave 13 WARD)

2-FULL NAME John J Braun

(a) RESIDENCE. No. 2410 McDermott Ave WARD. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? 81 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie R Braun

6 DATE OF BIRTH (month, day, and year) July 20/1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) — Builder

(c) Name of employer — Own

9 BIRTHPLACE (city or town) (State or country) — Balto Md

PARENTS

10 NAME OF FATHER George Braun

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Steger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Charles H Braun 152 Bayard St

15 Filed FEB 21 1921, 19 ROBERT B KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1920, to Feb 20, 1921, that I last saw h alive on Feb 19 1921, and that death occurred, on the date stated above, at 2.50 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland

(duration) 4 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical examination

(Signed) R B Norwood, M. D.

2.20.1921 (Address) 3043 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Feb 22 1921
20 UNDERTAKER	ADDRESS
Wm Cahoon & Radka	

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

D51066 HEALTH DEPARTMENT--CITY OF BALTIMORE 28 D51066

CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) Gays Frederick St. 5 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis R Daugherty

(Residence in Baltimore: No. Gay Frederick) (Years) 64 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct 23, 1856 (Month) (Day) (Year)

7-AGE, 64 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John A Daugherty

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Priscilla A Jessop

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Florence M Boyce

(Address) Talbot Apart

15- FEB 21 1921

Filed....., 191.... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Bronchitis most probably tuberculous

..... (Duration)..... yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pulmon Edema

..... (Duration)..... yrs.....mos.....ds.

(Signed) Wm Finlay M. D. (Coroner.)

2-21, 1921 (Address) 1629 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Lorraine Cem't DATE OF BURIAL, Feby 22 1921

20-UNDERTAKER, W. Buck ADDRESS 502 E Balto

Coroner Finlay M. Braithwaite

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51067

X 64-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wellham

(a) RESIDENCE. NO. Hanover Md ST.. WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. 24 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82 years	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Md.

PARENTS

10 NAME OF FATHER John Wellham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Geo H. Wellham

(Address) Hanover R R Co

15 Filed FEB 21 1921 MOLLIE I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1920, to Feb. 18, 1921, that I last saw him alive on Feb. 18, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia OVER

Cerebral Softening

(duration) yrs 4 mos. 18 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cyrus F. Horine, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wellhams A. A. Co	Feby. 21 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic hemiplegia
Terminal cerebral
hemorrhage.

Spec.—8-24-14—M. & T.—2000 Blks.

D51068 V 120 D51068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Hebrew Hospital St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Silverman

(Residence in Baltimore: No. 1008 E. Balto St. St.; 70 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 52 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Rumania

PARENTS.

10-NAME OF FATHER. Edward Silverman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isidor Silverman

(Address) 1008 E Balto st

15- FEB 21 1921 ROBERT J. KRAUTER Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 10 1921, to Feb 20 1921, that I saw h— alive on Feb 20 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

3

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
Uremia (Duration) yrs. mos. 10 ds.

(Signed) [illegible] M. D.

Feb 20, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1008 E Balto st

19-PLACE OF BURIAL OR REMOVAL, Hebrew Blair Rd

DATE OF BURIAL, Feb 24, 1921

20-UNDERTAKER Morris Levinson

ADDRESS 1174 Balto st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51069

1502

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Ruxton Ave St. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annette Feld

(a) RESIDENCE. No. 1607 Ruxton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? — yrs. 0 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Aug 21 24

7 AGE — Years — Months 6 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Frank A Feld

11 BIRTHPLACE OF FATHER (city or town) (State or country): America

12 MAIDEN NAME OF MOTHER: Ray Leibowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant (Address): Frank Feld 1607 N Ruxton Ave

15 Filed FEB 21 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923, to Feb 21, 1924, that I last saw her alive on Feb 20, 1924, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Congenital obliteration bile duct

(duration) — yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter C Bacon, M. D.

2/21/24 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Helen Rosedale — DATE OF BURIAL: Feb 24 1924

20 UNDERTAKER: J Peirson — ADDRESS: 1127 E Balto St

IMPORTANT: This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D51070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51070

CERTIFICATE OF DEATH.

REGISTERED No. C. 91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1401 Decatur St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Paul.

(Residence in Baltimore: No. 1401 Decatur St. St.: yrs., 4 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH, October 13th. 1920., 1
(Month) (Day) (Year)

7-AGE, ——— yrs. 4 mos. 7 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Lawrence Rush.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Margaret Paul

13-BIRTHPLACE OF MOTHER (State or Country), Austria.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Paul. (mother)

(Address) 1401 Decatur St.

15- FEB 21 1921 Filed ..... 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 20th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
unknown.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. H. Kessinardt M. D.
(Coroner.)

Feb., 20., 1921 (Address) 1017. S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross A.C. Co	2/21, 19.21
20-UNDERTAKER	ADDRESS
J. Fow McCully	1306 Fort.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state name of disease as carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

D 51071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51071

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1427 Andre St, ST. 24 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza J. Failer.

(Residence in Baltimore: No. 1427 Andre St.

62 ---------- St.; yrs., mos. ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, November 14th, 1853, 1
(Month) (Day) (Year)

7-AGE, 67 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Fort Macon N.C.

PARENTS.

10-NAME OF FATHER, Thomas J. Dailey.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Catherine Britt.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine B. Failer (daughter)

(Address) 1427 Andre St.

15- Filed FEB 21 1921, 191... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 18th, 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Eismandt M. D.
(Coroner.)

Feb 18th 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cem	2/22, 1921
20-UNDERTAKER	ADDRESS
J. Fenw McCully	130 E. Fort

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 51072

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51072

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH St. Agnes Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6 ST.; WARD)

2-FULL NAME Isaac Harris

(a) RESIDENCE. No. 1522 Odana ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Blanch alias Harris

6 DATE OF BIRTH (month, day, and year): Dec 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 04

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Ellen Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Matilda

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jacob Harris (Son) 2219 E. Monument St

15 Filed FEB 21 1921 ROBERT J. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-20-1921

17 I HEREBY CERTIFY, That I attended deceased from 2-17-21 to 2-20-1921 that I last saw him alive on Feb. 20, 1921 and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with extension to the Pancreas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. 1 ds.

Pulmonary Oedema

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 2-19-21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mech Rest	2/21 1921
20 UNDERTAKER	ADDRESS
Jack Levin	1411 E. Fayette

Spec.- 6-9-19—H. P. Co.- 1000 Bks.

D51073

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51073

CERTIFICATE OF DEATH.

28-092

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 N. Linwood ave ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Bruggman

(a) RESIDENCE. No. 703 N. Linwood Av ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 5-90

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Bruggman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Roth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ellen Armony

(Address) 703 N. Linwood

15 Filed. FEB 21 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20/21

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1921, to Feb. 20, 1921.

that I last saw her alive on Feb. 19, 1921,

and that death occurred, on the date stated above, at 12 15 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis laryngeal -

Acute lobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Dyspnea

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis

(Signed) Wm Kemit, M. D.

2/21 1921 (Address) 701 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	2/22/21
29 UNDERTAKER	ADDRESS
Philip Herring	2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51074 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51074

CERTIFICATE OF DEATH. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sefton Ave. near Glenmore Ave. (ST.) Hamilton (WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Albert Bertram Hoerr

(a) RESIDENCE. No. Sefton Ave. near Glenmore ave. (ST.) Hamilton (WARD.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 16th 1920

AGE: Years — Months: 3 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Maryland

PARENTS

10 NAME OF FATHER John Philip Hoerr

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie R. Bertram

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant John Philip Hoerr (Address) Hamilton Md.

15 Filed FEB 21 1921 19 Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1921, to Feb 21, 1921, that I last saw h.. alive on Feb 20, 1920, and that death occurred, on the date stated above, at 4.55 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geny L Long, M. D.

Feb 24 1921 (Address) 27 Hereford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb. 22 1921
20 UNDERTAKER	ADDRESS
Fred'k Lessar & Sons	Fullerton Md.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51075 D51075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 120-012

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 139 W. Lanvale ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Phila Pa

2-FULL NAME Eleanor C. Buck

(a) RESIDENCE. No. 139 W. Lanvale ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred -- yrs. 10 mos. -- ds. How long in U. S., if of foreign birth? -- yrs. 10 mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Buck

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Frederick Laverty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Hood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Ezra B. Whitman

(Address) 139 W. Lanvale Street

15 Filed FEB 21 1921 Registrar

Burial Permit Issued

Via Penn. Railroad, Escort Mrs. Ezra B. Whitman

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 11th, 1921, to Feb. 19th, 1921, that I last saw her alive on Feb. 19th, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death: No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Examin. Urinalysis

(Signed) S. C. Dodds, M. D.

. 19 (Address) 3101 Clifton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Hill Cemetery, Phila. — DATE OF BURIAL: 2/22, 1921

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to write MARGIN RESERVED. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51076

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51076

CERTIFICATE OF DEATH.

92-084

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 Presbury St.: 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Morton Russell

(a) RESIDENCE. No. 2121 Presbury St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 15, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George E. Russell

11 BIRTHPLACE OF FATHER (city or town) Arlington
(State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Mamie K. Brown

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Virginia

14 Informant George E. Russell
(Address) 2121 Presbury Street

15 Filed FEB 21 1921, 19 [illegible] Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2nd, 1921, to Feb 19th, 1921

that I last saw him alive on Feb 19th, 1921

and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis
(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) William J. Gessick, M. D.

Feb 19 1921 (Address) 1700 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	2/21 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51077

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 422-E 23 ST. 12 WARD)

2-FULL NAME Samuel M. Turner

(a) RESIDENCE. NO. 422 East 23 ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Atlanta Turner

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer) Cooking

(c) Name of employer Washington D. C.

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER James Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va. U.S.A.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Atlanta Turner

(Address) 422 East 23 St

15 Filed FEB 21 1921 19 ROBERT A. CRAWFORD Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1921, to Oct 18, 1921, that I last saw h[illegible] alive on Oct 18, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Bright Disease. Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By Gallbladder Incision

(Signed) By Garland Amoss M. D.

1924 (Address) 1534 E. H. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Auburn Cem.	Feb. 21 1921
20 UNDERTAKER Samuel J. Kemsley	ADDRESS W. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 51078

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 96 Ellemont ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Williams

(a) RESIDENCE. No. 96 Ellemont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. 6 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wilbur Williams Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah Hawkins

(Address) 96 Ellemont St

FEB 21 1921

ROBERT B. BRUTER

Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/16, 1921, to 2/19, 1921, that I last saw h[illegible] alive on 2/19, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Nasal and laryngeal diphtheria

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 96 Ellemont St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Jas. T. Boyle, M. D.

, 19 (Address) 336 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 2/21/21 1921

20 UNDERTAKER Sam. W. Chase-son

ADDRESS 1100 Mass Ave

Spdc.—6-9-19—H. P. Co.—1000 Bks.

D 51079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51079

CERTIFICATE OF DEATH.

146

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1013 S Bunney St ST.: 1 WARD)

2-FULL NAME Valentine Wm Pawlak

(a) RESIDENCE. NO. 1013 S Bunney St ST., 1 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year) 1890-Jan 5-

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Helper 186

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: St Oil Works

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Stan Pawlak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Pawlak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Mary Pawlak 1013 S Bunney St

15 Filed FEB 21 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1921, to Feb. 19, 1921, that I last saw him alive on Feb 18, 1921, and that death occurred, on the date stated above, at 515 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis due to
Mastoiditis 2 ds.

(Duration)

CONTRIBUTORY (Secondary) Convulsions (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. O. Neer M. D.

2/19/21, 19 (Address) 408 S Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem

DATE OF BURIAL: Feb 21 1921

20 UNDERTAKER: Stephen L Trakowski

ADDRESS: 1000 S Kenwood Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Exact CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 51080

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 S Decker Ave ST. OR WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Digos

(Residence in Baltimore: No. 729 S Decker Ave St. Yrs. 1 mos. ..... ds. ....)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Feb (Month) 16 (Day), 1911 (Year)

7-AGE.	If LESS than 1 day,
9 yrs. ..... mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. Pawel Digos

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Mary Kosuska

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pawel Digos

(Address) 729 S Decker Ave

15-

Filed FEB 21 1921, 191.....

ROBERT N KRAUTER
Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 15 1921, to Feb. 21 1921, that I saw h[illegible] alive on Feb. 20 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

(a) Endocarditis

.....

.....

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Chas Green M. D.

....., 191... (Address) 408 S Ann St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Cemetery — DATE OF BURIAL, Feb. 24, 1921

20-UNDERTAKER Stanley J Stackowski — ADDRESS 1000 Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51081 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51081

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 W. Cross ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Gauhan

(a) RESIDENCE. No. 1106 W. Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20 - 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Anthony Gauhan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Esther May

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss B. Gauhan

(Address) 1106 W. Cross st

15 Filed ..... 19 Robert F. Harrison, Registrar

21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Feb 9, 1921, that I last saw h~~im~~ alive on Feb 9, 1921, and that death occurred, on the date stated above, at 2 10 ~~P~~ m.

The CAUSE OF DEATH* was as follows:

Cerebro-Sclerosis-
Chronic interstitial nephritis

(duration) ? yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allen S. Birkhead, M. D.

, 19 (Address) 930 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 22 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S. Pac

IMPORTANT. Physicians should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51082 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51082

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3227 Colgate ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Raynor

(a) RESIDENCE. No. 3227 Colgate ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Capt-A.G. Raynor

6 DATE OF BIRTH (month, day, and year) July 6 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER James Montague

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Sarah Hand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant John Raynor (Address) 322 Colgate St.

15 Filed 19 Robert P. Harrison, Registrar

3 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 17. 19 21, to Feb 19 19 21, that I last saw her alive on Feb. 19. 19 21, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E. Kemp Gourley, M. D.

2/21/21 (Address) 2138 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Feby 22 1921
20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Balto St.

TION is very important. See instructions on back of certificates. at it may be properly classified. Exact statement of OCCUPA- State

Spec.—8-24-14—M. & T.—2000 Bks.

(Clarence Cockey)

D.51083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51083

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 195 Druid ST.; 17 WARD)

REGISTERED No. C 91

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Cockey

(Residence in Baltimore: No. 195 Druid St.; ... yrs., 9 mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 9th, (Month) (Day) 1912 (Year)

7-AGE, ... yrs. 9 mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Clarence L. Cockey

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Isabelle Howard

13-BIRTHPLACE OF MOTHER (State or Country), Balto. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Cockey

(Address) 195 Druid St.

15- Feb 4 1921, 191...

Robert P. Harrison, Registrar.

FEB 5 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 19th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 14th 1921, to Feb 19th 1921, that I saw h[illegible] alive on Feb 15th 1921, and that death occurred, on the date stated above, at 3:11 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

... (Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) ...

... (Duration) ... yrs. ... mos. ... ds.

(Signed) H. Lee Slater M. D.

Feb 25, 1921 (Address) 712 S. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Feb 17, 1921

20-UNDERTAKER Samuel T Hensleys Sons

ADDRESS 578 Riddle ave

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very ... should state ... may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51084 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51084

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 753 N. Saratoga St. 4 ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel J. Brown

(Residence in Baltimore: No. 753 N. Saratoga St.: 5 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Negro	married

6-DATE OF BIRTH, June 3, 1856
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
64 yrs. 8 mos. 17 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Steward
(b) General nature of industry, business, or establishment in which employed (or employer): Y.M.C.A.

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Henry A. Brown

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Jane Smothy

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matthew Brown

(Address) 753 N. Saratoga St

15- Filed FEB 21 1921, 191.....

Robert P. Harrison, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15th 191.., to June 20th 191.., that I saw h.. alive on June 19th 191.., and that death occurred, on the date stated above, at 1.. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) ..yrs. ..mos. 5 ds.

CONTRIBUTORY (Secondary) Senile Marasmus

(Duration) ..yrs. ..mos. 7 ds.

(Signed) J. Wm. Cassard M. D.

June 21st, 1921 (Address) 1815 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Chester Va	2/21, 1921
20-UNDERTAKER	ADDRESS
Jno. Geo. Hoffer	106 N. Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.51085 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51085

CERTIFICATE OF DEATH. X 175-004

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1. South Haupt St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willard W. Gray.

(Residence in Baltimore: No. (Evidence not) St.; yrs. 23 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single.

6-DATE OF BIRTH, ... not known ..... (Month) (Day) (Year)

7-AGE, 24 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Chauffeur for
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Government

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, James Gray

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Ann E Gillen

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James Gray

(Address) 138 Franklin St. Brooklyn N.Y.

15-

Filed FEB 21 1921, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 19, 191.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia - Sec by
Shock
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. K. M. Gurley M. D.
(Coroner)
2-21, 192.. (Address) 7 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Brooklyn New York	February 21 1921
20-UNDERTAKER	ADDRESS
Henry Hoyer Son	1301 E Eager St

THE PHYSICIAN should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51086 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51086

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 S Payson St.; 20th WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Miller

(Residence in Baltimore: No. 111 S Payson St. St.; ..... yrs., ... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct 18, 1921.
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 1 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Harry L Miller

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Julia Myers

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Clokey

(Address) 111 S. Payson St

15-

Filed ..... 191.. Robert P. Harrison, Registrar.

FEB 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 18 1921, to Oct 19, 1921, that I saw h[illegible] alive on Oct 19, 1921, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6 months)

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H Cleveland M. D.

Feb 21, 1921. (Address) 1729 E Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Feb 22, 1921

20-UNDERTAKER George H Schwab & Bro — ADDRESS Westfield Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 51087 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51087

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 Patapsco ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Hoffman

(a) RESIDENCE. No. 1736 Patapsco ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry L. Hoffman

6 DATE OF BIRTH (month, day, and year) March 1-180[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Eugene Donovan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Miss Colkley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Harry Hoffman (Address) Robert F. Garrison, Patapsco

15 Filed FEB 21 1921 19 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1921, to Feb 21, 1921, that I last saw h[illegible] alive on Feb 20, 1921, and that death occurred, on the date stated above, at 1-30A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

2 (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

, 19 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	2/23 1921
20 UNDERTAKER	ADDRESS
J. Fenwick McCully	1306 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51088 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51088

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 N. Wolfe ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Pickert.

(a) RESIDENCE. NO. 529 N. Wolfe ST., 7 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Joseph D. Pickert

6 DATE OF BIRTH (month, day, and year) Oct 19-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Beck.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Kunigunda Huebschman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John P. Pickert (Son) (Address) 529 N. Wolfe St.

15 Filed ... 19 ... Robert P. Harrison, Registrar

B21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan ... 19 21, to Feb 18 ... 19 21, that I last saw h[er] alive on Feb 18 ... 19 21, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrahms, M. D.

19 (Address) 2360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feb 22nd 1921

20 UNDERTAKER Lilly & Zeiler

ADDRESS 408 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51089 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51089

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3400 Ester Place ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Enfield

(a) RESIDENCE. No. 3400 Esterplace ST., WARD. New Freedom Pa.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widuwed, or Divorced (write the word)
Male	White	Widower.

5a If married, widuwed, or divorced HUSBAND of (or) WIFE of Martha H. Enfield

6 DATE OF BIRTH (month, day, and year) Nov 11th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer. 086

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Co Pa.

PARENTS

10 NAME OF FATHER Andrew J. Enfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary E. Blair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Sarah E. Stephens.

(Address) 3400 Ester Place

~~Robert P. Harrison,~~

FEB 21 1921. 19 Filed

Registrar

Burial Permit Clerk.

Sarah E. Stephens person in charge.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Feb 19, 1921

that I last saw h— alive on Feb 19, 1921,

and that death occurred, on the date stated above, at 8 a-m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John G. Owens M. D.

Feb 21, 1921 (Address) Farmers Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Freedom Pa.	Feb 23 1921

20 UNDERTAKER ADDRESS

John A. Moran 3000 E. Baltost

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51090 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51090

CERTIFICATE OF DEATH. 27 28

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE. No. Maple Ave. 3rd door West of Cedar Ave. (Overlea) ST., (2nd) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Boyon

(a) RESIDENCE. NO. Maple Ave. (Overlea) ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 21 1891

7 AGE — Years: 29 Months: 3 Days: 28 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None (Housework)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: William C. Boyon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Mary M. Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. Mary M. Boyon
(Address) Maple Ave. Overlea

15 Filed ..... 19 .....
Robert P. Harrison, Registrar

FEB 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 15, 1920, to Feby 19, 1921, that I last saw her alive on Feby 18, 1921, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter W White Jr., M. D.

2/20. 19 (Address) 2800 St Paul st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: February 22 1921

20 UNDERTAKER: Henry Horck Son — ADDRESS: 1301 E Eager

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51091

CERTIFICATE OF DEATH.

3 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1442 Fleet st ST.: 3 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph L. Sundermeyer.

(a) RESIDENCE. No. 1442 Fleet st ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 26-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Linen Room

(b) General nature of industry, business, or establishment in which employed (or employer): Professional

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: Joseph Sundermeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Mary Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: Form Sundermeyer.
(Address): 1442 Fleet st

15 Filed Robert F. ... Registrar

B 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15 1921, to Feb 18th 1921,
that I last saw him alive on Feb. 18th 1921,
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary Analysis

(Signed) Edward C. Feldmeier M. D.

2/23, 1921 (Address) 1711 E Edge st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 22 1921

20 UNDERTAKER: George J. Ruth ADDRESS: 1735 Harford ave

TION is very important. See instructions on back of certificates.

...ay be properly classified. Exact statement of OCCUPA-

...ARKER. PHYSICIANS should state

D.51092 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51092

CERTIFICATE OF DEATH.

REGISTERED No. C 134

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel M. Donald

(Residence in Baltimore: No. 617 N. Calhoun St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, May 17, 1895
(Month) (Day) (Year)

7-AGE, 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer): D&O

9-BIRTHPLACE, (State or Country), W Va

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country). W. Va

12-MAIDEN NAME OF MOTHER Lizzie Shanholtz

13-BIRTHPLACE OF MOTHER (State or Country). W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Bartlett

(Address) 537 N. Carey St

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit (Blank)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 DOH
Cerebral Hemorrhage
Duration of Coma, Cancer of Uterus (Duration) hours, mos. ds.
CONTRIBUTORY (Secondary) Neuralgia
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)
2-22-21, 191.. (Address) 617 Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death 2 mos. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Okonoko W. Va.	Feb 24, 1921
20-UNDERTAKER	ADDRESS
C. E. Fanning & Son	1931 E. Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Mercy Hospt. history → cause of abortion unknown

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51093 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51093

CERTIFICATE OF DEATH. X H1

1-PLACE OF DEATH University Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. Lombard & Green ST.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Caroline Gordon

(a) RESIDENCE. No. Woodhaven Long Island ST., WARD. Woodhaven L. I.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
F.	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur F. Gordon

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	-	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer): Home
(c) Name of employer: Newark N.Y.

9 BIRTHPLACE (city or town) (State or country) Newark N.Y.

PARENTS

10 NAME OF FATHER Alvin Merritt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Elizabeth Gregory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Arthur F. Gordon
(Address) Woodhaven, L.I.

15 Filed 2 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 - 1921

17 I HEREBY CERTIFY, That I attended deceased from January 24th, 1921, to February 21st, 1921, that I last saw her alive on February 21st, 1921, and that death occurred, on the date stated above, at 7 35 P m.

The CAUSE OF DEATH* was as follows:
Abdominal Carcinomatosis

over

.....(duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) J. M. Hundley Jr. M. D.

19 (Address) University Hospital, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newark N.Y.	Feb 22nd 1921
20 UNDERTAKER Bertram L. Gore	ADDRESS 1723 N. Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51094

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51094

CERTIFICATE OF DEATH.

19

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2113 Bolton St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edward Spurrier

(a) RESIDENCE. No. 2113 Bolton St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Spurrier

6 DATE OF BIRTH (month, day, and year) Oct. 11, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Div. Supt. B. & O. R.R.

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fred. Co. Md.

PARENTS

10 NAME OF FATHER Thos. B. Spurrier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fred. Co., Md.

12 MAIDEN NAME OF MOTHER Amy Spurrier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Emma Spurrier (Address) 2113 Bolton St.

15 Filed FEB 22 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 5th, 1921, to Dec. 20th, 1921, that I last saw him alive on Feb. 19th, 1921, and that death occurred, on the date stated above, at 10.45 A.m.

The CAUSE OF DEATH* was as follows:

Dropsy

(duration) yrs. mos. 1/4 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis Myocarditis Arterio sclerosis

Acute Nephritis 2 days (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard C. Silver, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Feby 22 1921

20 UNDERTAKER ADDRESS John Ortel Lee 1201 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks. Samuel Satta also known as Sater

D51095

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D51095

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Satta also known as Sater

(Residence in Baltimore: No. 1434 E Fayette St.: 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1866
(Month) (Day) (Year)

7-AGE, 65 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Peddler
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Sater

(Address) Atlanta Ga

15-

Filed FEB 22 1921 191.....

[illegible] Registrar.

Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 17 1921, to Feb 19 1921, that I saw h[illegible] alive on 4 pm 192[illegible], and that death occurred, on the date stated above, at 4 [illegible]m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2½ ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) L Gershberg M. D.

Feb 19, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State 3 yrs. mos. ds.

Where was disease contracted, if not at place of death? 1434 E Fayette St

Former or usual residence Atlanta Ga

19-PLACE OF BURIAL OR REMOVAL, Hebrew Nursing Home — DATE OF BURIAL, 2-22, 1921

20-UNDERTAKER Jack Levis — ADDRESS 1410 Eutaw

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 N. Pattenson Pk Ave ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Lorenz.

(a) RESIDENCE. No. 914 N. Pattenson Pk Ave ST., 7 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Lorenz.

6 DATE OF BIRTH (month, day, and year) Jan 25-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder. 147

(b) General nature of industry, business, or establishment in which employed (or employer) Shipyard.

(c) Name of employer Iron Foundry

9 BIRTHPLACE (city or town) Balto.
(State or country) md.

PARENTS

10 NAME OF FATHER Engelbut Lorenz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anna Lorenz
(Address) 914 N. Pattenson Pk Ave

15 Filed FEB 22 1921 ROBERT J. KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 13th, 1921, to May 18th, 1921, that I last saw h... alive on Feb 18th, 1921, and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Diffuse Bronchitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Lowe, M. D.

1921 (Address) 1501 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Feb 22 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—R. P. Co.—1000 Blks.

D51097 HEALTH DEPARTMENT—CITY OF BALTIMORE D51097

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor, 10 WARD)

2-FULL NAME Sarah Hart.

(a) RESIDENCE. NO. Preston & Valley Sts. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 17-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~1 month~~	72	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Annie Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sister Florence.
(Address) Preston & Valley

15 Filed FEB 22 1921 [illegible] LEAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from No record, 19, to, 19,
that I last saw h[illegible] alive on Feb 20, 1921,
and that death occurred, on the date stated above, at 11.45 a.m.
The CAUSE OF DEATH* was as follows:

Valvular Disease of heart
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. L. Warner, M. D.
Feb 20, 1921, (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Feb 22 1921
20 UNDERTAKER	ADDRESS
Leo G. Cook	North Harford [illegible]

IT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

051098

HEALTH DEPARTMENT—CITY OF BALTIMORE.

051098

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 St Vincent Ave ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Farr

(a) RESIDENCE. NO. 2 St Vincent Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 13 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Emanuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Dr Meatheus

(Address) 1401 Division St

15 Filed FEB 22 1921 Wm. J. KRAUTER Registrar Social Security Dist

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1921

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1921, to July 18, 1921, that I last saw her alive on July 18, 1921, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (8) Months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Heavilon M.D.

July 18 1921 (Address) 15 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Feb 22 1921
20 UNDERTAKER	ADDRESS
M Tuley & Son	1827 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D51099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51099

CERTIFICATE OF DEATH.

X 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD 14)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Martin

(a) RESIDENCE. No. Keplung P.O. St. a WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Martin

6 DATE OF BIRTH (month, day, and year) Feb. 14 1887

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
34		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Baytham Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Cath. Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Elwood Hallonee

(Address) 131 Elm St Curtis Bay

15 Filed FEB 22 1921 [illegible] KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 14, 1921, to Feb 21, 1921, that I last saw him alive on Feb 21, 1921, and that death occurred, on the date stated above, at 11 45 a.m.

The CAUSE OF DEATH* was as follows:

Obliteration of Stomach

Empyema, Left Side Pleura

0882

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Infection of Peritoneum

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? Yes Date of Feb 15,

Was there an autopsy? Yes

What test confirmed diagnosis? Operation + Autopsy

(Signed) Wm D. Baetzly M. D.

2/22, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Keplung Va - Via Tappahannock M. D. & V. R.R.	Feb 22 1921
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	716 LIGHT ST.

IT IS IMPORTANT that this Certificate of Death be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51100

92.079

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Wheeler.

(a) RESIDENCE. No. 612 William ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) American Ice Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William H Wheeler

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Hunt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mrs W. Annie Caldwell
(Address) 612 Williams St

15 Filed FEB 22 1921 19 ROBERT F. LAMOTTE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from February 18, 1921, to February 21, 1921, that I last saw him alive on February 21, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. A. Schenick, M. D.

19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WESTERN	FEB 23 1921

20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

THIS is very important. See instructions on back of certificates. Be sure to fill in all items properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 4

CITY OF BALTIMORE: (NO. Ida E ST.: 15 WARD)

2-FULL NAME Mrs. ~~Edward~~ F. Shadrick (Ida)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 2909 Clifton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, ~~widowed, or divorced~~ (HUSBAND) of (or) WIFE of Edward F. Shadrick (dec.)

6 DATE OF BIRTH (month, day, and year) July. 14, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	60	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John L. Clark

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Bertha A. Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs C.E. Mirst
(Address) 2909 Clifton ave

15 Filed FEB 22 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1921, to Feb. 20, 1921, that I last saw her alive on Feb. 20, 1921, and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 29, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) Geo. E. Hardy, M. D.

19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feby 23rd 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

Gaines

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51102 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51102

CERTIFICATE OF DEATH.

X 107

1-PLACE OF DEATH University Hospital

REGISTERED NO. 4

CITY OF BALTIMORE: (No. ..... ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard E. Gaines

(a) RESIDENCE. NO. Cardiff Md. ST., ... WARD. Cardiff Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 25 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Luella Gaines

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant S. W. Holden
(Address) Delta, Pa.

15 Filed FEB 22 1921, 19 ..... ROBERT A. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1920, to Feb. 21, 1921, that I last saw him alive on Feb 21, 1921, and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric ulcer
General peritonitis. Sub-
Phrenic abscess

(duration) ..... yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

..... (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? ..... Dec 27, 1920

Did an operation precede death? Yes Date of Feb. 17, 1921.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cyrus F. Adams, M. D.

, 19 (Address) University Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Delta Pa — DATE OF BURIAL: Feb 22 1921

20 UNDERTAKER: Wm J Pinkerton Sons — ADDRESS: North Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 57103

D 57103

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 536 Walnut St. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Richards

(a) RESIDENCE. No. 536 Walnut ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Thos. Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Emma Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Mary Robinson
(Address) 536 Walnut alley

15 Filed FEB 22 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 9 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1919, to Feby 19, 1921, that I last saw him alive on Feby 18, 1921, and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 17 mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Samuel Hammett, M. D.

2/22, 1921 (Address) 1006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Feb 22 1921
20 UNDERTAKER	ADDRESS
Saml H Toadvine	142 Hill St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51104

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 London Ave STR. 21 WARD)

2-FULL NAME Jacob Weishaar

(a) RESIDENCE. No. 203 London Ave STR. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Weishaar

6 DATE OF BIRTH (month, day, and year): March 27th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Carroll County Md.

PARENTS

10 NAME OF FATHER: Michael Weishaar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Reaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant: Mary E. Weishaar

(Address): 203 London Ave

15 Filed FEB 22 1921 WORTH P. KEFAUVER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 20 1921

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1916, to Feb. 20, 1921, that I last saw him alive on Feb. 20, 1921, and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Duration

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Locomotor Ataxia

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W. Jones M. D.

2.20. 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 23rd 1921

20 UNDERTAKER: Patrick A. Hannon

ADDRESS: 1911 N. Londay St.

TION is very important. See instructions on back of certificates.

Anton Horky

D51105

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51105

70

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. Eye, Ear Throat Hospital ST. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonia Horky

(a) RESIDENCE. No. 62 N. Johnston ST., WARD. Baltimore

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? 7 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josefa Horky

6 DATE OF BIRTH (month, day, and year) Oct 6-1893

7 AGE: Years 27 Months 4 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Brother Louis Horky

(Address) 2736 W. Fairmount Ave

15 Filed FEB 22 1921 ROBERT A. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1921, to Feb. 21, 1921, that I last saw h— alive on Feb. 21, 1921, and that death occurred, on the date stated above, at 6:35 P m.

The CAUSE OF DEATH* was as follows:

Acute Mastoiditis

Lateral Sinus Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 2-21-21

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) L. F. Fitzman, M. D.

2-24, 1921 (Address) 625 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 24 1921
20 UNDERTAKER	ADDRESS
F. B. Herbert	2236 Eutaw Ave

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 51106

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51106

CERTIFICATE OF DEATH.

REGISTERED NO. 19113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 McHenry St. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin W. Knight

(a) RESIDENCE. No. 1610 McHenry St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kane Knight

6 DATE OF BIRTH (month, day, and year) Mch. 4" 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) (B&O. Lumber Yard)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John B. Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Olevia Sheckell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Mary Kane Knight
(Address) 1610 McHenry St.

15 Filed FEB 22 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20" 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 4, 1921, to Feby 20, 1921, that I last saw him alive on Feby 19, 1921, and that death occurred, on the date stated above, at 5.55P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

3

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ...

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

2/24. 1921 (Signed) M. Friedl, M. D. (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sewell Md	Feb 23 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 E Baltimore Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 172

CITY OF BALTIMORE: (No. 1218 W. Fayette St. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Jane Gatch

(a) RESIDENCE. NO. 1218 W. Fayette St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles H. Gatch

6 DATE OF BIRTH (month, day, and year): May 26" 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Philip Sitzler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Katherine Strhick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Miss Lillian E. Gatch

(Address): 1218 W. Fayette St.

15 Filed FEB 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 30" 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 1921, to Feb. 20, 1921, that I last saw h- alive on Feb 21, 1921, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia (Chronic)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Fracture of Hip

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A Cairns, M. D.

. 19 (Address) 10 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Feb 22 1921
20 UNDERTAKER: Jno B Cook	ADDRESS: 1003 N Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 51108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51108

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp. ST.: 11 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert M. Combs

(Residence in Baltimore: No. Druid Apartments St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	married

6-DATE OF BIRTH March (Month) 8 (Day), 1858 (Year)

7-AGE, 62 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamen
(b) General nature of industry, business, or establishment in which employed (or employer): Ships

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Moses Combs

11-BIRTHPLACE OF FATHER (State or Country), Maine

12-MAIDEN NAME OF MOTHER Lydia Rhea

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Combs

(Address) Custmaker!

15- ROBERT A. LEAUTIER

Filed FEB 22 1921, 191.... Chief Clerk and Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

Cerebral Hemorrhage

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) W. S. Riley M. D. (Coroner.)

Feb 22, 1921. (Address) 1637 Ruxton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Feb. 23, 21

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St

important. See instructions on back of certificate.

D51109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Pratt & President St.; 6 WARD)
REGISTERED No. C 792

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Frank
(Residence in Baltimore: No. 24 N. Castle St.)
Life St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.
4-COLOR OR RACE, W.
5-SINGLE, MARRIED, WIDOW'ED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct. 15, 1897
(Month) (Day) (Year)

7-AGE, 23 yrs. 5 mos. 5 ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION;
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Weaver
11-BIRTHPLACE OF FATHER (State or Country), Balto Md
12-MAIDEN NAME OF MOTHER Barbara Weaver
13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Barbara Weaver
(Address) 24 N. Castle St.

15-
Filed FEB 22 1924 191.... MURRAY B. LEAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 20, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Ryan Kneisly M. D.
(Coroner)
2-27-24, 191.. (Address) 8 Courtland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Feb. 27, 1924

20-UNDERTAKER Mendell Dippel & Son — ADDRESS 37 S. Amer St.

Please write DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Succ.—6-9-19—H. P. Co.—1000 Bks.

D51110

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No. ..... ST.: 23 WARD) 115

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cesare Bologna

(a) RESIDENCE. No. 1100 S Ann ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ..... ms. ..... ds. How long in U. S., if of foreign birth? 30 yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 140

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Alessandro Castagneli (Address) 1100 S Ann St

15 Filed FEB 22 1921 ROBERT A. CARTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1921, to Feb 19, 1921, that I last saw him alive on Feb 19, 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

a Carcinoma

- Mediastinum

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Pleurisy

(Signed) F. C. Marino M. D.

2-19, 1921 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 22 1921

20 UNDERTAKER Wendell Appel & Son ADDRESS 378 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 5 1111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 5 1111

CERTIFICATE OF DEATH.

REGISTERED NO. C 5 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 N. Central ave. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel L. Jolly

(Residence in Baltimore: No. 635 N. Central ave. St.; about 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widower

6-DATE OF BIRTH, ? ? 1834
(Month) (Day) (Year)

7-AGE, 87 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Mill hand
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Dorchester Co, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Washington

(Address) 635 N. Central Ave.

15- FEB 22 1921 Filed ....., 191.... [illegible] KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 21, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 21 1921, to Feb. 21 1921, that I saw h[illegible] alive on Feb 20 " 1921, and that death occurred, on the date stated above, at 2.00 a.m.

The CAUSE OF DEATH* was as follows:

1 Cerebro Hemorrhage
2 Hypertrophy of Heart
3 Nephritis
(Duration) four months

CONTRIBUTORY (Secondary) Unknown
(Duration) about a year

(Signed) Mayfield Hoyle M. D.

2/22/, 1921. (Address) 724 N. Carolina

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery

DATE OF BURIAL, Feb. 23, 191...

20-UNDERTAKER Chas M. Bailey

ADDRESS 1491 Jefferson st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Bennett Place ST.: 16 WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Charles A. Sederberg

(a) RESIDENCE. No. 910 Bennett Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary S Sederberg

6 DATE OF BIRTH (month, day, and year) April 3 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Sederberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Julia Wesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Chester Sederberg
(Address) 910 Bennett Place

15 Filed FEB 22 1921 BOYER & KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9 1921, to Feb. 22 1921, that I last saw him alive on Feb. 21 1921, and that death occurred, on the date stated above, at 1:50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis
Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) R. C. Methot, M. D.

2/22 1921 (Address) 1403 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 24 1921
20 UNDERTAKER Geo W Little	ADDRESS 531 N Fremont Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Clovis M Thompson

D 51113

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 79

CITY OF BALTIMORE: No. 212 E. Montgomery ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clovis M. Thompson

(a) RESIDENCE. No. 212 E. Montgomery ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 21 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Life

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Clovis Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Emma E Thompson

(Address) 212 E Montgomery

15 Filed FEB 22 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924, to Feb 20, 1924, that I last saw h alive on Feb 20, 1924, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Valvular Heart disease

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Hawkins M. D.

2/22 1924 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Feb 23 1924
20 UNDERTAKER	ADDRESS
Isaac Deford & Son	Baltimore

IMPORTANT is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 755 W Cross St., 21 WARD) REGISTERED NO. C 74

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Mineburg

(Residence in Baltimore: No. 755 W Cross St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, Dec 14th, 1888
(Month) (Day) (Year)

7-AGE, 32 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Postal Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Mineburg

11-BIRTHPLACE OF FATHER (State or Country), Ohio Cincinnati

12-MAIDEN NAME OF MOTHER Ida Herdrich

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Mineburg

(Address) 755 W Cross St

15- FEB 22 1921 Filed, 191 ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 18th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to Feb 18 1921, that I saw him alive on Feb. 18 1921, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Tumor of brain in right occipital lobe

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage in brain about 2 hrs,

(Duration) yrs. mos. ds.

(Signed) Walter S. Niblett M. D.

Feb 18, 1921 (Address) 2220 Garrison Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery — DATE OF BURIAL, Feb 22, 1921

20-UNDERTAKER Robt L Turner — ADDRESS 1442 N Broadway

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D57115 HEALTH DEPARTMENT—CITY OF BALTIMORE D57115

105

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 Laurens ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Jackson

(a) RESIDENCE. No. 1836 Laurens ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 54 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Andrew Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Suffie Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Helena Jackson (Address) 1836 Laurens St

15 Filed FEB 22 1921 [illegible] Dead-Clerk

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/16, 1921, to 2/18, 1921, that I last saw h[illegible] alive on 2/16, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Ac. Gastro-enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burk Klutz, M. D.

, 19 (Address) 2134 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Feb. 21 1921

20 UNDERTAKER: Edw. Pungold — ADDRESS: 1463 Carey

Instructions on back of certificates. Make statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D57116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D57116

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 Parrish ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Eades.

(a) RESIDENCE. NO. 903 Parrish ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Child

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) June 8/1920

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	✓	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 005

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Eades.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co. Md.

12 MAIDEN NAME OF MOTHER Ella Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co Md

14 Informant Geo. A. Shannon (Address) 700 Fulton Ave

15 Filed FEB 22 1921 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry 21/1921

17

I HEREBY CERTIFY, That I attended deceased from Febry 18, 1921, to Febry 21, 1921, that I last saw her alive on Febry 21, 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis — (see back)

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy?

What test confirmed diagnosis? Usual diagnostic methods

(Signed) Geo. A. Shannon M. D.

2/24, 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Feb 23 1921
20 UNDERTAKER	ADDRESS
Edw. Ringgold	1463 Carey

IT is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51117

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

D 51117

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3310 Foster ave. St.: 26 Ward)

2-FULL NAME Rita Anna Dreyler.

(a) RESIDENCE. No. 3310 Foster Ave St., 26 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH MUST BE A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2nd 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John J. Dreyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary E. Ebauer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John J. Dreyler
(Address) 3310 Foster ave.

15 Filed FEB 22 1921 19.. ROBERT J. KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 17 1921, to Feb 18 1921, that I last saw h alive on Feb 18 1921, and that death occurred, on the date stated above, at 3 00 a. m.

The CAUSE OF DEATH* was as follows:

Pacific Enteric Catarrh

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Stoner, M. D.

Feb 21, 1921 (Address) 1501 E. Eager st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Feb. 22 1921
20 UNDERTAKER Lilly & Zeeler	ADDRESS 405 S. Mosher

D 51118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51118

CERTIFICATE OF DEATH.

1752.01

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Zahner.

(Residence in Baltimore: No. 912 S. Decker Ave. St.; 22 yrs., 8 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Single.

6-DATE OF BIRTH. June 15th. 1898 (Month) (Day) (Year)

7-AGE. 22 yrs. 8 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Zahner.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Mary Kaiser.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Hale. (uncle)

(Address) 1107 S. Boulden St.

15- FEB 22 1921 Filed ....., 191.... ROBERT A KRAUTH Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 19th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an authsy & inves (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage of the brain.
Fracture of the skull.
Accidental fall from an automobile truck. (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. W. Leonhardt M. D. (Coroner.)

Feb. 20., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Accident. Hanover & Church Sts.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart Cem.	Feb 23, 1921
20-UNDERTAKER Libby & Zahn	ADDRESS 1033 S. Wolfe

Important. See instructions on back of certificate. Causes should be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51119

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 154 D 51119

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2137 E.Oliver ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Price

(a) RESIDENCE. No. 2137 E.Oliver ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of James Price

6 DATE OF BIRTH (month, day, and year) Feb.14.1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER Thomas Ford

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rebbecca Naghle

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Lillie Battersly(daughter)
(Address) 2137 E.Oliver St.

15 Filed FEB 22 1921 ROBERT J. BRAUER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb.20, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Feb 2, 1921, that I last saw her alive on Feb 19, 1921, and that death occurred, on the date stated above, at 3;30 P m.

The CAUSE OF DEATH* was as follows:

Exaustion, & Infirmities of age

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Infirmities

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ~~Clinical~~ Clinical

(Signed) D B Carman, M. D.

2 22 1921 (Address) 1701 N Carolina st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 23. 1921
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 51120

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51120

CERTIFICATE OF DEATH.

91

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 McElderry st. ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Izier Small

(Residence in Baltimore: No. 1404 McElderry st St.; ..... yrs., 11 mos. ..... ds.)

Important. See instructions on back of certificate. Causes of death should state properly classified. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. March 21, 1920.
(Month) (Day) (Year)

7-AGE, ... yrs. 11 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... —
(b) General nature of industry, business, or establishment in which employed (or employer) 0 0

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Samuel Small

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Martha Garrison

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Pinkham

(Address) 1704 Eutaw pl.

15- FEB 22 1921

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 21, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 14 1921, to Feb 21 1921, that I saw him alive on Feb 21 1921, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

..... Bronchio pneumonia

.....

.....

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. Pinkham M. D.

Feb 21, 1921. (Address) 1804 Eutaw pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cmtry — DATE OF BURIAL, Feb 24, 1921

20-UNDERTAKER Mrs Robt a Elliott — ADDRESS 1725 Eastern ave

Remarks

No infection prior

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137-9 P.K. Russell Bro. U.D.

REGISTERED NO. D 51121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3904 Fernwood Ave ST.: 826 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jannette Merritt

(a) RESIDENCE. No. 3904 Fernwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clay Merritt

6 DATE OF BIRTH (month, day, and year) Nov 15 97

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Krol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clay Merritt
(Address) 3904 Fernwood Ave

15 FEB 22 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1922, to Feb 19, 1921, that I last saw her alive on Feb 19, 1921, and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Septicemia following Miscarriage (duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Charles L. Crook M. D.

Feb 17 1921 (Address) 503-05 E Third St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Feb 22, 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	110 Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51122 HEALTH DEPARTMENT—CITY OF BALTIMORE D51122

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2423 Woodbrook Ave WARD 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Weisskopf

(a) RESIDENCE. NO. 2423 Woodbrook Ave STR. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE: Years 48 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Data City

PARENTS

10 NAME OF FATHER Joseph Weisskopf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cecelia Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Weisskopf
(Address) 2424 Woodbrook

15 Filed FEB 22 1921 ROBERT P. PRUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from August, 1919, to July 20, 1921, that I last saw he alive on July 20, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual Clinical

(Signed) Thomas J. Talbott M. D.

, 19 (Address) Marlborough Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Feb 22 1921
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51123

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 S. Bond ST.; 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Sobus

(a) RESIDENCE. NO. 621 S Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? 3 yrs. 7 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmale

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1-1917

7 AGE: Years 3 Months 7 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Sobus

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Rosalie Nelkowski

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Peter Sobus. (Address) 621 S. Bond St

15 Filed FEB 22 1921 19 MORRIS F. REGITZ Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1921, to Feb 21 1921

that I last saw her alive on Feb 21 1921

and that death occurred, on the date stated above, at 8:20 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy? .....

*What test confirmed diagnosis? .....

(Signed) J. W. Ramsey M. D.

19 (Address) 1801 N Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.	Feb 23 1921
20 UNDERTAKER M F Sadowski.	ADDRESS 905 S Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51124

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51124

CERTIFICATE OF DEATH.

92-010

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 655 Sterling ST. 5 WARD)

2-FULL NAME William Brown

(a) RESIDENCE. NO. 655 Sterling ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Elizabeth Brown 655 Sterling St

15 FEB 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/15/21, 19..., to 2/20/21, 19..., that I last saw him alive on 2/19/21, 19..., and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? as above

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert L. Levy M.D.

, 19 (Address) 1207 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 23 1921
20 UNDERTAKER	ADDRESS
Emil Easton	916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51125

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N Patterson Park Ave ST. 6 WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George N Wise Jr

(a) RESIDENCE. No. 419 N Patterson Park Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Wise

6 DATE OF BIRTH (month, day, and year) Feby 22, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	11	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph operator.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Dorothy Herbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary E Wise (Address) 419 N Patterson Ave

15 Filed FEB 23 1921 ROBERT J. BAKER Registrar

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 — 19 21, to Feb 20 — 19 21, that I last saw h— alive on Feb 20 19 21, and that death occurred, on the date stated above, at 11 0 m.

The CAUSE OF DEATH* was as follows:

Valvular - Cardiac Dis - Chronic —

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

1 hour — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Manual

(Signed) M D Brooks M. D.

, 19 (Address) 125 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feby 23 1921
20 UNDERTAKER	ADDRESS
J Kerr & Co	26 Fulton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51126

CERTIFICATE OF DEATH.

92-010

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH E.

CITY OF BALTIMORE: (No. 1925 Lafayette Ave ST.: 8 WARD)

2-FULL NAME. Mary W. Grape

(a) RESIDENCE. NO. 1928 Lafayette a ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John Grape

6 DATE OF BIRTH (month, day, and year) June 18 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Whitehill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant John Grape (Address) 1928 Lafayette Ave

15 Filed FEB 23 1921 ROBERT I. CRAIG Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 18, 1921, to Feby 20, 1921, that I last saw h alive on Feby 19, 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. W White Jr, M. D.

, 19 (Address) 2800 N Paca st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Feb 23 1921
20 UNDERTAKER J Herwig & Co	ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51127

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51127

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 W. Clement ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Mary Carr

(a) RESIDENCE. NO. 6 W. Clement ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 26, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none Off

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Martin Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Carrie And 2/22 1921

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Martin Carr (Address) 6 W. Clement St.

15 FILED FEB 23 1921 MORRIS A. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18th, 1921, to Feb 19th, 1921, that I last saw h[illegible] alive on Feb 19th, 1921, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 6. W Clemant St

Did an operation precede death? no Date of

Was there an autopsy? no Health Dept.

What test confirmed diagnosis? Laboratory Ex. of Sputa

(Signed) J. W. Keown, M. D.

(Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Feb. 23 1921
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51128

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 Aisquith St. 25 42 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Haas

(a) RESIDENCE. No. 201 Patapsco & Brooklyn, St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Andrew Haas

6 DATE OF BIRTH (month, day, and year) May 24, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungaria

PARENTS

10 NAME OF FATHER Henry Apuy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungaria

14 Informant Andrew Haas (Address) 201 Patapsco Ave Brooklyn

15 Filed FEB 23 1921 19 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 1920 to July 20th 1921, that I last saw h... alive on July 20th 1921, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

General Cancer

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 30/20

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Brady M. D.

, 19 (Address) 1340 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Dallas

DATE OF BURIAL Feb 23 1921

20 UNDERTAKER Margaret B. Flynn

ADDRESS 1432 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D51129 HEALTH DEPARTMENT—CITY OF BALTIMORE D51129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Womans Hospital St. 14 WARD) REGISTERED No. C 159

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabelle D. Lloyd-

(Residence in Baltimore: No. 1621 Park Ave. St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Mar 27, 1891. (Month) (Day) (Year)

7-AGE 29 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), California

PARENTS.

10-NAME OF FATHER, Ashley Carter

11-BIRTHPLACE OF FATHER (State or Country), Cal.

12-MAIDEN NAME OF MOTHER Alice Littlefield

13-BIRTHPLACE OF MOTHER (State or Country), Cal.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Daniel J Bowers
(Address) 162 Park ave

15-
Filed FEB 23 1921 ROBERT J. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 20, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wounds
Suicide
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo Edwin Black M. D.
(Coroner.)
2/21/21 101 (Address) 743 No Paca

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cem	July 23, 1921
20-UNDERTAKER John O. Mitchell	ADDRESS 1701 W Fayette

Important. See instructions on back of certificate. PHYSICIANS should state exact statement of OCCUPATION is very may be properly classified.

JONES

D51130 HEALTH DEPARTMENT—CITY OF BALTIMORE D51130

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 5911

CITY OF BALTIMORE (No. 1407 E Fairmount St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Jones.

(Residence in Baltimore: No. 1407 Fairmount St.; 5/12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Sgl.

6-DATE OF BIRTH, May (Month) 20th (Day), 1920 (Year)

7-AGE, ...yrs. 1 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of Industry, business, or establishment in which employed (or employer): 900

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Ernest Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jones

(Address) 1407 Fairmount Ave

15- Filed FEB 23 1921, 19.... Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Lobar Pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner.)

2-24-21, 19.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Arbury Cem. DATE OF BURIAL, Feb 23 19 21

20-UNDERTAKER Harry A. Vodrey ADDRESS 1725 Orleans St

Penalty: See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51131

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51131

CERTIFICATE OF DEATH.

91-036

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 N Mulberry ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E Russo

(a) RESIDENCE. No. 614 N Mulberry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Peter Russo

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy.

12 MAIDEN NAME OF MOTHER Anine Fabrig

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Indiana

14 Informant Mr Peter Russo
(Address) 614 N Mulberry St

15 Filed FEB 23 1921 ROBERT I. KRAUSE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17th, 1921, to Feb. 21st, 1921, that I last saw h.im alive on Feb. 21st, 1921, and that death occurred, on the date stated above, at 3.30 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William Dew, M. D.

. 19 (Address) 1742 Moreland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Feb 23 1921
20 UNDERTAKER	ADDRESS
W. M. Ponton.	230 N Green

IT IS VERY IMPORTANT. See instructions on back of certificates. Cause of death may be properly classified. Exact statement of OCCUPATIONS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51132

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51132

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View WARD) 19

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Brown.

(a) RESIDENCE. NO. 1508 W. Baltimore St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1838.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Brown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

14 Informant Records.

(Address) City Hospital, Bay View

15 FEB 23 1921 ROBERT A. LEAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1921, to Feb. 20, 1921, that I last saw h.. alive on Feb. 20, 1921, and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis (No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) Postoman, M. D.

Feb 20, 1921 (Address) City Hospital, Bay View.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	2/23/21

20 UNDERTAKER W M Bartson ADDRESS 230 N Green

Sec. 5. ... shall be properly classified. Exact statement of OCCUPATION should state ... See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 662 W Lexington ST.; 4 WARD)

2-FULL NAME John J R Krozes

(a) RESIDENCE. No. 662 W Lexington ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 30, 1827

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	93	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) — 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elizabeth City N. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant James Krozer

(Address) Ewing & Mill Roland

15 Filed FEB 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Feb 21, 1921, that I last saw him alive on Feb 21 1921, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumania

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) a fall + Shock

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? +

Did an operation precede death? no Date of +

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) V Van Williams, M. D.

, 19 (Address) 601 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 24 1921
20 UNDERTAKER George J Smith	ADDRESS 1000 W Fayette St

TION is very important. See instructions on back of certificates.

Size 6-9-19—H. P. Co.—1000 Bks.

D51134 HEALTH DEPARTMENT—CITY OF BALTIMORE D51134

CERTIFICATE OF DEATH. 64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Aged Mens Home St., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry L Fairchild

(a) RESIDENCE. No. 1400 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W H

5 Single, Married, Widowed, or Divorced (write the word): Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May — 1842

7 AGE: Years 78 | Months 7 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Wayne Co Mich.

PARENTS

10 NAME OF FATHER Wm Fairchild

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Nancy Conkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant H. W. Fillman
(Address) Marion

15 FEB 23 1921 ROBT. P. LEA... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Feb 21, 1921, that I last saw h... alive on Feb 21, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia
Old

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Atherosclerosis Heart
Nephritis (duration) yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Feb, 1921 (Address) 909 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Feb 23 1921

20 UNDERTAKER: George J Smith — ADDRESS 1000 Fayette

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Originally apoplectic hemiplegia. No terminal hemorrhage.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 51135

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 Woodbury Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph V. Baker, Jr

(Residence in Baltimore: No. 2025 Woodbury Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Infant

6-DATE OF BIRTH, ...Jan.... (Month) 6th (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 1 mos. 16 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph V Baker,

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Kepner

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph V. Baker

(Address) 2025 Woodbury Ave

15- FEB 23 1921 Filed....., 191... Burial Permit Issued

ROBERT H. KRAUTZ

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 20th 1921, to Feb 22 1921, that I saw h[illegible] alive on Feb 21st 1921, and that death occurred, on the date stated above, at 11 A.m.

The CAUSE OF DEATH* was as follows:

Lueral Thrombus with marked Nasal Hemorrhage

None

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) None

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. A. Friend M. D.

2/23/21, 191... (Address) 1127 Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Govans — DATE OF BURIAL, Feb 23 1921

20-UNDERTAKER Chenoweth Son — ADDRESS Cheatum Ave

IMPORTANT. See instructions on back of certificate. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very properly classified. Exact statement of CAUSE OF DEATH is necessary, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51136

CERTIFICATE OF DEATH.

REGISTERED NO. 502

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View WARD 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary O'Neill

(a) RESIDENCE. NO. ?1220 Hanover Ave ST., WARD. 13.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced (write which word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE — Years: 65 — Months: — — Days: — — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Daniel O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Margaret McConl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Records (Address) City Hospital, Bay View

15 Filed FEB 23 1921 19 ~~BURIAL A REMOVAL~~ Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1921, to Feb. 22, 1921, that I last saw h.. alive on Feb. 22, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.
(Old cerebral thrombosis)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes mellitus.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) [illegible], M. D.

Feb 22 1921 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Feb 25 1921

20 UNDERTAKER: Austin Fahey & Sons — ADDRESS: 827 N. [illegible]

PHYSICIANS should state plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Ellsworth Ray

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51137 D51137

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 W Lafayette ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellsworth Ray

(Residence in Baltimore: No. 1114 W Lafayette St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Oct 8, 1904
(Month) (Day) (Year)

7-AGE, 16 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Dr

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Lemmi Ray

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Rena Hammond

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ella Cornish (Niece)

(Address) 1114 W Lafayette

15- FEB 23 1921 BOARD OF HEALTH

Filed ....., 191.. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 20, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1920, to Feb 20 1921, that I saw h[e] alive on Feb 19 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

..... (Duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ... yrs. 2 mos. ... ds.

(Signed) C.W. Flowers M. D.

Feb 22, 1921 (Address) 712 S. Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Feb 23, 1921

20-UNDERTAKER Brown & Fleeland ADDRESS 1140 N. Schroeder St

Form 6-9-19—H. P. Co.—1000 Blks.

D 51138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51138

CERTIFICATE OF DEATH.

9-091

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

2-FULL NAME John Wasljaw

(a) RESIDENCE. No. 1126 William ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred —yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Wasljaw.

11 BIRTHPLACE OF FATHER (city or town) Hungary
(State or country)

12 MAIDEN NAME OF MOTHER Mary Adam

13 BIRTHPLACE OF MOTHER (city or town) Hungary
(State or country)

14 Informant John Wasljaw
(Address) 1126 William St.

15 Filed FEB 23 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 21, 1921, to Feb 22, 1921, that I last saw him alive on Feb 22, 1921, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. (3) 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Positive culture

(Signed) B Macpherson, M. D.

2/22/21 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	2-23 1921
20 UNDERTAKER	ADDRESS
Edward B Hart & Co	115 E Madison

Important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state what kind of work the person did, even though he may not be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

1617 E Eager

D 51139

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51139

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 N. Durham ST.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Frederick Emery -

(Residence in Baltimore: No. 1809 N. Durham St. St. 21 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb (Month) 7 (Day), 1899 (Year)

7-AGE, 22 yrs. ..... mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Allen L Emery

11-BIRTHPLACE OF FATHER (State or Country), N Carolina

12-MAIDEN NAME OF MOTHER Oliveria Buckley

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Allen L Emery

(Address) 1809 N. Durham St.

15- FEB 23 1921 BUREAU OF STATISTICS

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 21 1921, to Feb 22 1921, that I saw him alive on Feb 22 1921, and that death occurred, on the date stated above, at 8-15 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia -

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. Gill Hall M. D.

Feb 22, 1921 (Address) 1617 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bal Cemetery	Feb 25, 1921

20-UNDERTAKER	ADDRESS
Wm Cook	502 E N. Ave

...ment of OCCUPATION is very

FEB 23 1921

Spec.—8-24-14—M. & T.—2000 Bks.

D 51140 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D51140

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3530 Chestnut Ave St.; 13 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas H. Joy

(Residence in Baltimore: No. 3530 E Chestnut Ave St.; 40 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb (Month) 13 (Day) 1846 (Year)

7-AGE, 75 yrs. mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Jeweler 038
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Thomas Joy

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Harriett Baine

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Helga B Joy

(Address) 3530 Chestnut Ave

15- FEB 23 1921 REGISTRAR'S

Filed....., 191..... Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1920, to Feby 21 1921, that I saw him alive on Feb. 20 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lumbago (Duration) yrs. mos. 4 ds.

(Signed) [illegible] M. D.

2/22, 1921 (Address) 20 20 St Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Freeland Md	Feb 27, 1921
20-UNDERTAKER	ADDRESS
A S Marshall	2539 Fall Rd

Spec.—8-24-14—M. & T.—2000 Bks.

D51141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51141

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 W 33 St ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leah Shaffer

(Residence in Baltimore: No. 602 W. 33 1/2 St St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug 3, 1857 (Month) (Day) (Year)

7-AGE, 63 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 837

9-BIRTHPLACE, (State or Country), York Co Pa

PARENTS.

10-NAME OF FATHER, John Kirchner

11-BIRTHPLACE OF FATHER (State or Country), York Co Pa

12-MAIDEN NAME OF MOTHER Polyanna Ehrhardt

13-BIRTHPLACE OF MOTHER (State or Country), York Co Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Kuss

(Address) 602 W 33 St

15-

Filed FEB 23 1921, 191.... ROBERT A LAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 21, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 29 1920, to Feb 21 1921, that I saw her alive on Feb 20/21 1921, and that death occurred, on the date stated above, at 7:20 AM

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Left Hem. Hemiplegia

(Duration) ..... yrs. 6 mos. 22 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) A. D. Shedden M. D.

Feb 21, 1921. (Address) 3542 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Feb 23, 1921

20-UNDERTAKER A D Marshall — ADDRESS 3539 Ellerslie

Please fill out all items of certificate. Statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

Transcribed

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 5 1142

CERTIFICATE OF DEATH.

D 5 1142

91

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2917 Dillon St ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L Gransee

(a) RESIDENCE. No. 2917 Dillon St ST., 1 WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Sept 14 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md U S A

PARENTS

10 NAME OF FATHER John Wm Gransee

11 BIRTHPLACE OF FATHER (city or town) Rosedale
(State or country) Balto Co Md U S A

12 MAIDEN NAME OF MOTHER Jenovia Wielinska

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md U S A

14 Informant Jenovia Gransee
(Address) 2917 Dillon St

15 Filed FEB 23 1921 19 [illegible] Registrar

Burial Permit Issued

TION is very important. See instructions on back of certificates. If it may be properly classified. Exact statement of OCCUPA- should state

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1921, to Feb 21, 1921, that I last saw him alive on Feb 21, 1921, and that death occurred, on the date stated above, at 11 30 p.m.

The CAUSE OF DEATH* was as follows:

OVER

Bronchopneumonia

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) H H Tilden M. D.

2/22, 1921 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Feb 23 1921
20 UNDERTAKER	ADDRESS
Stephen J Fialkowski	Mt Clare

Spec.—6-3-19—H. P. Co.—1000 Blks.

D51143

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51143

CERTIFICATE OF DEATH.

1879

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 N Amity ST.; ..... WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number.)

2-FULL NAME Sylvester Newman

(a) RESIDENCE. No. 207 N Amity ST., ... WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa Newman

6 DATE OF BIRTH (month, day, and year): Unknown 1866

7 AGE: 55 Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Ann Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Louisa Newman
(Address) 207 N Amity St

15 Filed FEB 23 1921 ROBERT I. CRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1921, to Feb 19, 1921, that I last saw h alive on Feb 17, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease Heart

(duration) yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Pulm Oedema

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? h

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Feb 1, 1921 (Address) 937 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem | DATE OF BURIAL: Feb 23 1921

20 UNDERTAKER: Samuel A Hensley Middle | ADDRESS 578

THION is very important. See instructions on back of certificates. ... may be properly classified. Exact statement of OCCUPA... should state ... that it may

Spec.—8-24-14—M. & T.—2000 Bks.

D51144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51144

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2010 Homewood Av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Tyson

(Residence in Baltimore: No. 2010 Homewood Av St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Aug 15, 1871
(Month) (Day) (Year)

7-AGE, 49 yrs. 6 mos. 6 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Richmond Va Not Known

PARENTS.

10-NAME OF FATHER, Dennis C Sullivan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. V. Tyson

(Address) 2010 Homewood Ave

15- Filed FEB 23 1921, 191.... ROBERT A KRAUTER Registrar. VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/16 1921, to 2-21 1921, that I saw h.. alive on 2-20 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

a Cerebral Hemorrhage

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) D Brennan M. D.

2/21, 191.. (Address) 614 E Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Feb 24, 1921
20-UNDERTAKER	**ADDRESS**
E A Windsfeld Jr	501 E 12 St

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified. Exact statement of CAUSE OF DEATH should state

Remarks No hemorrhage. No further history.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

D51145 HEALTH DEPARTMENT—CITY OF BALTIMORE D51145

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2007 Homewood St. 9 Ward)

REGISTERED No. C 979

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Bent

(Residence in Baltimore: No. 2007 Homewood St.; yrs. 66 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, April (Month) 15 (Day), 1841 (Year)

7-AGE, 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Sea Capt.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Nova Scotia

PARENTS.

10-NAME OF FATHER, Joseph Bent

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER — Harris

13-BIRTHPLACE OF MOTHER (State or Country), New York.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph E. Bent

(Address) 2007 Homewood Ave

15- Filed FEB 23 1921 191... ROBERT A KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Knox Hanley M. D. (Coroner)

2-22, 1921 (Address) 4 E. Mt. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Feb 25, 1921

20-UNDERTAKER C A Winefordner — ADDRESS 501 E 22 St

Use instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—5-19-13—M. & T.—500 Bks.

D 51146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51146

CERTIFICATE OF DEATH.

91

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2516 N. Pratt ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy F. Boughan

(Residence in Baltimore: No. 2516 N. Pratt St.; ..... yrs., 2 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec (Month) 6 (Day), 1920 (Year)

7-AGE, ... yrs. 2 mos. 14 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frederick Boughan

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Florence Harris

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Boughan

(Address) 2516 N. Pratt St

15-Filed FEB 23 1921, 191.... ROBERT J. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 20 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 10 1921, to Feb 20 1921, that I saw h er alive on Feb 20 1921, and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchitis, acute endocarditis

(Duration) ..... yrs. ..... mos. 9 ds.

(Signed) Hattie E. Tuckman M. D.

Feb 22 1921 (Address) 2002 N. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount DATE OF BURIAL, Feb 23, 191 21

20-UNDERTAKER A. B. Applegarth ADDRESS 2236 Eutaw Pl

D51147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51147

CERTIFICATE OF DEATH.

154

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 709 E. Eager ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Valentine Meyer

(Residence in Baltimore: No. 709 E. Eager St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, Jan. 20, 1841
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
37 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): OHO

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Valentine Meyer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Helen Rupp

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Meyer

(Address) 709 E. Eager St.

15- FEB 23 1921 Filed ..... 191... BOYLE & REUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shrewds by Pistol

Min (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Feb. 24, 19 21

20-UNDERTAKER	ADDRESS
H. C. Rudefeld	4 W. Green

Be sure that every question is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

25 1148

HEALTH DEPARTMENT—CITY OF BALTIMORE

25 1148

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1382 Woodyear St. WARD) 15 15 52

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Willie & Lottie Goodman

(Residence in Baltimore: No. 1382 Woodyear. St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Col	Inf'c

6-DATE OF BIRTH, Feb 22, 1921.
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....1.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Werley Goodman

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Louis Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Werley Goodman

(Address) 1382 Woodyear St.

15- FEB 23 1921 ROBERT A. CRAWFORD Burial Permit Clerk

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 22, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(Duration) .....yrs.....mos.....1.....ds.

CONTRIBUTORY (Secondary) Premature Confinement

(Duration) .....yrs.....mos.....1.....ds.

(Signed) C. E. Pfaff M. D.
(Coroner.)

2/23/21 191... (Address) 1342 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Feb 23, 1921
20-UNDERTAKER	ADDRESS
James H Dennis	1303 Pennsylvania Ave

...may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

251149 HEALTH DEPARTMENT—CITY OF BALTIMORE 251149

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1633 Rice ST.: 15 WARD) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Thomas

(Residence in Baltimore: No. 1633 Rice St.; yrs., mos. ds.)

Type

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.)
Female	Col	Single

6-DATE OF BIRTH, ... Unknown ....., 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
35 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknow

11-BIRTHPLACE OF FATHER (State or Country) Unknow

12-MAIDEN NAME OF MOTHER Unknow

13-BIRTHPLACE OF MOTHER (State or Country), Unknow

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Dennis

(Address) 1303 Presstman

15- FEB 23 1921

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

.....

.....

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

.....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Lull M.D. Phds

(Coroner.) ..... M. D.

2/20/21, 191... (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Feb 23 1921
20-UNDERTAKER James H Dennis	ADDRESS 1303 Presstman

Instructions on back of certificate. Exact statement of OCCUPATION is very important and should be carefully studied. Every question should be answered. If any cause of death has existed for a long time, the contributory (secondary) cause should be stated.

Stepter.

D51150 HEALTH DEPARTMENT—CITY OF BALTIMORE D51150

CERTIFICATE OF DEATH.

X 92

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1020 N Caroll ST.: 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Stepter

(Residence in Baltimore: No. 1020 N Carey- St.: yrs., mos. 14 ds.)

Instructions on back of certificate. Exact statement of OCCUPATION is very important and should state whether employer or employed, or if working on own account. Write plainly and fill all blanks with word or words making full answer. If none, write none.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col	Single

6-DATE OF BIRTH, ... January ....., 1 .....
(Month) (Day) (Year)

7-AGE, 24 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknow

12-MAIDEN NAME OF MOTHER Unknow

13-BIRTHPLACE OF MOTHER (State or Country), Unknow

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H Dennis

(Address) 1303 Presstman St

15- Filed FEB 23 1921 191..... MOVED A CHAPTER Burial Permit Given Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 / 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Tuberculosis Pulmonalis

(Duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Virginia

19-PLACE OF BURIAL OR REMOVAL, Va DATE OF BURIAL, Blackwell Northumb Co Feb 22 1921

20-UNDERTAKER James H Dennis ADDRESS 1303 Presstman

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51151 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 5213 Denmore Ave 27 105 REGISTERED NO.

CITY OF BALTIMORE: (No. ~~[illegible]~~ 5213 Denmore ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Hammond.

(a) RESIDENCE. No. 5213 Denmore ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: 89 (Years / Months / Days) If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknow

(b) General nature of industry, business, or establishment in which employed (or employer) 057

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknow

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknow

12 MAIDEN NAME OF MOTHER unknow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknow

14 Informant James H Dennis (Address) 1303 Presstman St

15 Filed FEB 23 1921 ROBT. A. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/21, 1921, to 2/21, 1921, that I last saw h[illegible] alive on 2/20, 1921, and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

1st Ac. Gastro-enteritis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B W Rhutta, M. D.

, 19 (Address) 2[illegible]3 Dr of Hea[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Airy P.R.R. DATE OF BURIAL: Feb 24 1921

20 UNDERTAKER: James H Dennis ADDRESS: 1303 Presstman

Directions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-51152

HEALTH DEPARTMENT—CITY OF BALTIMORE

29

D-51152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1340 Ashburton St. (Ward) 7

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adlena Rintoph

(a) RESIDENCE. NO. 619 N Decker St., WARD. 24

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman H Rintoph

6 DATE OF BIRTH (month, day, and year): 1867. Jan 14

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Charleston S. C.

PARENTS

10 NAME OF FATHER: William Sobrecht.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Charlotte Frieder.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Herman H. Rintoph 619 N. Decker ave

15 Filed FEB 23 1921, 19.... Registrar

Central Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1921, to July 20, 1921, that I last saw h[e]r alive on July 20, 1921, and that death occurred, on the date stated above, at 6 H m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Negro Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 2/9/21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A Kentrupp, M. D.

, 19 (Address) 1340 Ashburton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fifth Reform Cemetery, Harford Road — DATE OF BURIAL: Feb 23 1921

20 UNDERTAKER: Mrs C. Miller — ADDRESS: 2334 Jefferson

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH may be necessary to establish cause of death. Exact statement of CAUSE OF DEATH may be necessary to establish cause of death.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51153

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51153

CERTIFICATE OF DEATH.

696

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 228 h Kenwood ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth a Zornoltan

(a) RESIDENCE. No. 228 h Kenwood ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August F Zornoltan

6 DATE OF BIRTH (month, day, and year) Oct 10-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Strueblein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carl F Zornoltan

(Address) 228 h Kenwood ave

15 Filed FEB 23 1921 [illegible] KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 19 21

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 19 21, to Feb 21, 19 21, that I last saw h e alive on Feb 21, 19 21, and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Paralysis

over

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma ?

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C F Meyer, M. D.

1921 (Address) 1638 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuel Cemetery	Feb 24 1921
20 UNDERTAKER	ADDRESS
Mrs C Miller	2330 Jeffers ave

IMPORTANT: This certificate may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history. Only attended short time. No history of any chronic organic heart trouble. Physician was certain was not T. B.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51154

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Belt St.; 24 WARD) REGISTERED NO. C 792

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Anne Ghent

(Residence in Baltimore: No. 1723 Belt St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1825 (Year)

7-AGE, 95 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Work
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Kent Co Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Kent Co Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eva Geoghegan

(Address) 1723 Belt St.

15- FEB 23 1921 Filed ....., 191... [illegible] KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/18 1921, to 2/20 1921, that I saw h[illegible] alive on 2/20 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Old age

(Duration) 5 yrs. mos. ds.

(Signed) L J Durlington M. D.

2/22, 191... (Address) 102 E Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park	2/23, 1921
20-UNDERTAKER	ADDRESS
C J Fanning	961 Hollins

Spec.—8-24-14—M. & T.—2000 Bks.

Neoma Wakefield

D51155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51155

8,091

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 W.m Elderry ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Neoma Wakefield

(Residence in Baltimore: No. 2201 W.m Elderry St St.; ....yrs., 5 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	

6-DATE OF BIRTH, September (Month) 5 (Day) 1920 (Year)

7-AGE, ...yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Charles Wakefield

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Anna Gebhardt

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Wakefield

(Address) 2201 W.m Elderry

15- FEB 23 1921 ROBERT E KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 23 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 13 1921, to Febuary 22 1921, that I saw her alive on February 22 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

.....

.....

Whooping Cough.

..... (Duration) ....yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

..... (Duration) ....yrs. .... mos. 12 ds.

(Signed) Frank J Kind M. D.

....., 191... (Address) 2006 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	2/24, 1921
20-UNDERTAKER Philip Heinig	ADDRESS 2016 Orleans

Exact statement of OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D5 1156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D5 1156

CERTIFICATE OF DEATH.

92-011

REGISTERED NO. 7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 949 N. Washington ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward L. Cunningham

(a) RESIDENCE NO. 949 N. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pattern Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer American Brass Co

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Edward Cunningham

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Agnes Hay

13 BIRTHPLACE OF MOTHER (city or town) Pittsburgh
(State or country) Penn.

14 Informant James L. Cunningham
(Address) 946 N. Washington St.

15 Filed FEB 23 1921 19.... ROBERT E. KRAUTER Registrar
Burial Permit: Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1921, to Feb. 21, 1921, that I last saw him alive on Feb. 21, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .... yrs. .... mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) .... yrs. .... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) Allen G. Siegrad M. D.

2/22, 1921 (Address) 161 E. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Feb 24 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D51157

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51157

CERTIFICATE OF DEATH.

91-089

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 615 W Redwood ST.; 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bistriekas

(a) RESIDENCE. No. 615 Redwood ST. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 87 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)
experience

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female.

4 COLOR OR RACE White.

5 Single, Married, Widowed, or Divorced (write the word) Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Martin Bistriekas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Kuzeikiz Kas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant—(Address) Wm Bistriekas 615 W Redwood St

15 Filed FEB 23 1921 ROBERT E. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1921, to Feby 23 1921, that I last saw her alive on Feby 23 1921, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute bronchitis

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) M C Swiengerd M.D.

1921 (Address) 682 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb. 14 1921
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca St.

THIS is very important. See instructions on back of certificates. ... may be properly classified. Exact statement of OCCUPA-... should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 61158 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 25 Ward) REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Richardson

(a) RESIDENCE. No. St. Agnes Hosp St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred since yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	over

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46 yrs.				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer) Dr
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know

PARENTS
10 NAME OF FATHER " " "
11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know
12 MAIDEN NAME OF MOTHER " " "
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Charles Richardson
(Address) St Agnes Hospital JOHNS HOPKINS HOSPITAL

15 Filed MAR 3 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21 192

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1919, to Feb. 21, 192, that I last saw him alive on Feb. 21, 192, and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis and Aortitis.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S Livingston, M. D.
, 19 (Address) St Agnes.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL,	FEB 23 1921
20 UNDERTAKER Commissioner Health.	ADDRESS

It is very important that this certificate be properly classified. Exact statement of OCCUPATIONS should state what is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably married.
Whether or not wife
was living unknown.
Not kept for some years

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51159

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51159

CERTIFICATE OF DEATH.

X 104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2634 Oswego Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Thomas Himes

(a) RESIDENCE. NO. 2634 Oswego Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 22. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Williamsport Pa

PARENTS

10 NAME OF FATHER Albert B. Himes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lura B. Schell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Williamsport Pa

14 Informant Albert B. Himes
(Address) 2634 Oswego Ave, City

Filed FEB 23 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1921, to Feb 22, 1921, that I last saw him alive on Feb 22, 1921, and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Toxic Diarrhoea

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) G W Billups, M. D.

. 19 (Address) 2224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Williamsport Penna	Feb 24 1921
20 UNDERTAKER	ADDRESS
W J Tuckerman	North Pa

(1) Before writing, see that you have properly classified. Exact statement of OCCUPATION should state particular kind of work, and not merely laborer, clerk, etc. (2) See instructions on back of certificates.

Spec.—6-9-1)—H. P. Co.—1000 Bks.

D. 51160

D. 51160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1921 REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Md Gen. Hosp ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. W. Lamerson

(a) RESIDENCE. No. 406 N. Fricket ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) ? 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Young Felden

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jno Lamerson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Miss Pullman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Mary E Berry
(Address) 406 N Fricket

15 Filed Feb 25 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1921, to Feb 23, 1921, that I last saw him alive on Feb 23, 1921, and that death occurred, on the date stated above, at 10.15 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred D. Bamfield M. D.

2/23 1921 (Address) Maryland Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charles Town WVa	Feb 25 1921
20 UNDERTAKER W J Turner Jr	ADDRESS N. Y. Pa

Instructions on back of certificates. Exact settlement of OCCUPA- should state properly classified.

Spec.—5-19-13—M. & T.—500 Bks.

D.51161 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51161

CERTIFICATE OF DEATH.

REGISTERED No. C 792

1-PLACE OF DEATH
CITY OF BALTIMORE, (No. 2229 Callow Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin J. Griffin

(Residence in Baltimore: No. 2229 Callow Ave St.; 69 yrs., — mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August 28, 1852
(Month) (Day) (Year)

7-AGE, 69 yrs. — mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER Thomas H. Griffin

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary West

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Edwin Griffin

(Address) 2229 Callow Ave

15- Robert P. Harrison,

Filed 1 1921, 191.... Registrar.

Muriel Perrill Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 191.., to February 22 1921, that I saw h.. alive on February 22 1921, and that death occurred, on the date stated above, at 12.50 a m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(Duration) 2 yrs. mos. ds.

(Signed) H L Kolrath M D.

....., 191... (Address) 128 W Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount. DATE OF BURIAL, Feb. 25, 1921

20-UNDERTAKER W J Zickner & Sons ADDRESS N. Y Pa

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51162 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51162

CERTIFICATE OF DEATH. 43

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1655 N. North St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Emily Gosnell

(a) RESIDENCE. No. 1655 N. Northam St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Washington R. Gosnell

6 DATE OF BIRTH (month, day, and year) January 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida Belle Burton (Address) 1655 N North

15 Filed 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10 1920, to Feb. 20th 1921, that I last saw her alive on Feb. 20th 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of right breast.

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Isaac C. Dickson, M. D.

19 (Address) 3055 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb. 24 1921
20 UNDERTAKER	ADDRESS
H. Blackwood Sons	Norwood Pa

Exact statement of OCCUPA- ... on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D. 51163 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51163

CERTIFICATE OF DEATH. 20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Waldner Crouch (Crowl)

(a) RESIDENCE. NO. Garrison & Belmont Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Pearre E Crowl

6 DATE OF BIRTH (month, day, and year): Nov 28 1865

7 AGE: Years 55 Months 2 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 037

(b) General nature of industry, business or establishment in which employed (or employer)

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Christian C Gerber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pelts Md

12 MAIDEN NAME OF MOTHER: Louisa V Waldner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pelts Md

14 Informant: Pearre E Crowl

(Address): Belmont & Garrison

15 Filed ..... 19.....

Robert F. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan Feb 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 13 1921, to Feb 24 1921, that I last saw h alive on Feb 21 1921, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Regurgitation

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus viridans Sept. acemia (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) Fred J. Baumgartner, M. D.

Feb 24, 1921 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem — DATE OF BURIAL: Feb 24 1921

20 UNDERTAKER: Wm J Tickner & Sons — ADDRESS: N. Pa

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- be stated EXACTLY. PHYSICIANS should state be properly classified. Every item of information

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51164 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51164

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3021 Mc. Elderry St.; 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret F. Moore

(a) RESIDENCE. No. 3021 Mc. Elderry St., Ward.
(Usual place of abode) (If nonresident give City or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Moore,

6 DATE OF BIRTH (month, day, and year) June 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Jas. Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER M. Fitzgebld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Danl. Moore (Address) 3021 Mc. Elderry St.

15 Filed 2 3 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1921, to Feb 21 1921, that I last saw h[illegible] alive on Feb 21 1921, and that death occurred, on the date stated above, at 7 P.M. The CAUSE OF DEATH* was as follows:

Arteriosclerosis &
Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical, Microscopic

(Signed) J. H. Thomas, M. D.

Feb 23 1921 (Address) 1228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisburg, Penna	Feby 25th 1921

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks. Exact statement of OCCUPATION should be properly classified. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

20.51165

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51165

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1220 Fidrel st ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret A. O'Connel.

(Residence in Baltimore: No. 1220 E. Fidrel st. St.; 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH, April 6th, 1870
(Month) (Day) (Year)

7-AGE, 51 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House-Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, James Conner

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER M. Gormley.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas V. O'Connel

(Address) 1220 E. Fidrel st

15-

Filed 2/3/1921 Robert P. Harrison, M.D. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 23, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 8 1921, to Feb 23 1921, that I saw her alive on Feb 23 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cardio-Pulmonary

..... (Duration) Instant yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) Instant yrs. ..... mos. ..... ds.

(Signed) Benj. H. Hayden M. D.

Feb 23, 1921. (Address) 1216 N. Carrollton Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Feb. 26 1921

20-UNDERTAKER George J. Ruth ADDRESS 735 Hanford Av.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51166

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51166

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 262 S Spring ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Hereene

(a) RESIDENCE. NO. 262 S Spring ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mollie Hereene

6 DATE OF BIRTH (month, day, and year) March 17 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Brunswick.

PARENTS

10 NAME OF FATHER Edward Hereene

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Brunswick

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mollie Hereene
(Address) 262 S Spring

15 Filed 3 19 27 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15th 1921, to Feb. 21st 1921,

that I last saw him alive on Feb. 20th 1921,

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? * * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Fingerwood, M. D.

2/23 1921 (Address) 5 N. Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 23 1921
20 UNDERTAKER	ADDRESS
Wendell Appel Son	374 Mn

Important: See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51167 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51167

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N. Mount St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J. Weisenthal

(a) RESIDENCE. No. 13 N. Mount St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Weisenthal

6 DATE OF BIRTH (month, day, and year) Feb 13th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

(c) Name of employer Mt Clare shop Baltimore Md

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary E Seffford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Dolly F Cunningham (Address) 13 N Mount St

15 Filed 3 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21st 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1921, to Feb 21, 1921, that I last saw h[illegible] alive on Feb 21, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edward O. Cunningham, M. D.

, 19 (Address) 24 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	2-25 1921
20 UNDERTAKER	ADDRESS 17
Robert Brooks & Son	S. Calhoun St

Important. See instructions on back of certificates. Exact statement of OCCUPA. should state the properly classified.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51168 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51168

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1224 Mc Elderry ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Giuseppe E. Fulco

(a) RESIDENCE. No. 1224 Mc Elderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 9-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Giuseppe Fulco Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Nettie Costanzo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant (Address) Giuseppe Fulco Jr 1224 Mc Elderry

15 Filed Robert P. Harrison, Registrar

2 23 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 20th, 1921, to Feb. 23rd, 1921, that I last saw him alive on Feb. 23rd, 1921, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George G. Gross, M. D.

, 19 (Address) 2409 Mad. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery	7/24/21

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hanover

Note.—It is very important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51169

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51169

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 10 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sr. M. Flavia Comitilla Thomas

(a) RESIDENCE. No. St. Francis Convent, Chas. St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 1, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer) 065

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mother Francis (Address) St. Catharine's Post Office

15 Filed ..... 19 Robert P. Harrison, Registrar

3 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/20, 1921, to 2/22, 1921, that I last saw h[illegible] alive on 2/22, 1921, and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Ruptured Intestine.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/20/21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis D. Ridgely, M. D.

2/22/1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cemetery	Feb 24 1921

20 UNDERTAKER	ADDRESS
Felix B Rye	10 E. Mulberry

Should state exact statement of OCCUPATIONS. Should be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51170 HEALTH DEPARTMENT—CITY OF BALTIMORE. D.51170

CERTIFICATE OF DEATH. X 120

1-PLACE OF DEATH US. Public Health Service Hosp. #56 REGISTERED NO.....

CITY OF BALTIMORE: (NO. Fort Mc Henry Baltimore Md ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henning

(a) RESIDENCE. NO. US. Public Health Service Hosp. #56 ST. WARD. Chicago Ill

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) ----

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43 yrs.	0----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman.

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ------

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edw. J. Rauchfuss Registrar (Address) Fort McHenry Baltimore Md.

15 Filed 3 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21 1921, to Feb. 21 1921

that I last saw him alive on Feb. 20 1921

and that death occurred, on the date stated above, at 8-10 pm

The CAUSE OF DEATH* was as follows:

Nephritis chronic, interstitial.

----- (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ----

Was there an autopsy? No

What test confirmed diagnosis? Laboratory report.

(Signed) Thomas R. Payne P.A Surgeon.

19 (Address) Ft. McHenry Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

21 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chicago Ill	Feb 23 1921
20 UNDERTAKER S. Fenwick + Bro	ADDRESS 1127 E Balto St

Should state OCCUPATION in all cases. Exact statement may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 51171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D 51171

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 Druid Hill Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter W. Pinderhughes Jr

(Residence in Baltimore: No. 1203 Druid Hill Ave St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 18 (Day) 1915 (Year)

7-AGE, 5 yrs. 8 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Walter W. Pinderhughes Jr

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Dixie Stubbs

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dixie Stubbs

(Address) 1203 Druid Hill Ave

15- FEB 24 1921 [illegible] KRAUTER

Filed ....., 191.... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 22 1921, to Feb 23 1921, that I saw h[illegible] alive on Feb 23 1921, and that death occurred, on the date stated above, at 11 00 a.m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Tonsilitis

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) [illegible] M. D.

Feb 23, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn Cemetery — DATE OF BURIAL, Feb 24, 1921

20-UNDERTAKER John H. Fondrude — ADDRESS 162 N. Hill St

Fill out all questions if possible. Exact statement of OCCUPATION is very important. Use black ink. Write plainly. Do not fold certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Division ST.; 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Matthews

(a) RESIDENCE. NO. 2120 Division ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Matthews

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas R Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henrietta Matthews

(Address) 2120 Division St

15 Filed FEB 24 1921 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21-1921

17

I HEREBY CERTIFY, That I attended deceased from 1-9-, 1921, to 1-21-, 1921, that I last saw him alive on 1-18-, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Bargill, M. D.

2-23-1921 (Address) 611 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Feb 24 1921
20 UNDERTAKER	ADDRESS
Samuel T Hemsley	1913 McCulloh

TION is very important. See instructions on back of certificates.

...may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51173

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 Harford Ave ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Smith.

(a) RESIDENCE. NO. 732 Harford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Smith

6 DATE OF BIRTH (month, day, and year) June 15 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Atlanta Georgia

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Atlanta Georgia

14 Informant Herbert L. Smith
(Address) 1727 - E. Lanvale

15 Filed FEB 24 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1 1921, to February 23 1921, that I last saw her alive on February 23, 1921, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lung
Tuberculosis of Lung
Chronic Bright Disease.

(duration) 1 yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis & Bright Disease (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. H. Kennard, M. D.

2-23 1921 (Address) 708 Cator St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	2/26 1921
20 UNDERTAKER	ADDRESS
Williams Corle	502 E North

IMPORTANT: PHYSICIANS should state clearly and fully all facts required. Every question must be properly answered. Unless this is done it may be returned for correction. Cause of death must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51174

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51174

CERTIFICATE OF DEATH.

REGISTERED NO. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2654 Florence ST.: 13 WARD)

2-FULL NAME Franklin Bond

(a) RESIDENCE. NO. 2654 Florence ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1 April 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant 000

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Campbell

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Bond

13 BIRTHPLACE OF MOTHER (city or town) Bela Haven
(State or country) North Carolina

14 Informant Mother Bertha Bond
(Address) 2654 Florence St

15 Filed FEB 24 1921 ROBERT J. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 22 Febuary 1921

17 I HEREBY CERTIFY, That I attended deceased from 15 Feb. 1921, to 21 Feb. 1921, that I last saw h m alive on 21 Feb. 1921, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, Acute

(duration) 0 yrs. 0 mos. 15 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Gilbert W Rosenthal, M. D.

23 Feb 1921 (Address) 2227 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	2/24 1921
20 UNDERTAKER William Cook	ADDRESS 502 E Hoff

IMPORTANT. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51175

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Norwood & Brightwood Ave. Ward 26) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mettie M. R. Kirwan

(a) RESIDENCE. No. Norwood & Brightwood Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/0 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Albert E. Kirwan

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER Charles Kolfod

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Margaret Carpenter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Albert E. Kirwan
(Address) Norwood & Brightwood Ave

15 Filed FEB 24 1921 19 ROBERT J. BRAUER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1919, to Feb 23, 1921, that I last saw her alive on Feb 22, 1921, and that death occurred, on the date stated above, at 9 45 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual examinations

(Signed) Frank M. Kelly M. D.

2/23 1921 (Address) 243 W. Mary Land Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	2/26/21
20 UNDERTAKER Harry W. Ehlen	ADDRESS 194 W. Monument

TION is very important. See instructions on back of certificates. ...it may be properly classified. Exact statement of OCCUPA... ...in plain terms, so that it ma... ...PHYSICIANS should state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51176

CERTIFICATE OF DEATH.

80-091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1172 N. Luzerne ave ST.; 6 WARD)

2-FULL NAME John R. Whittemore

(a) RESIDENCE. No. 1172 N. Luzerne ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Whittemore

6 DATE OF BIRTH (month, day, and year) Dec. 18, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	2	3	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Stove Manufacturer

(c) Name of employer Isaac Sheppard

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John R Whittemore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Fannie Whittemore (Address) 117 N. Luzerne Ave.

15 Filed FEB 24 1921 ADELE F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1921, to Feb. 21, 1921, that I last saw him alive on Feb. 20, 1921, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Grunine angina pectoris 3 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (mechanical) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Objective Symptoms

(Signed) G. G. Page, M. D.

2-24 1921 (Address) Charles & Preston Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb. 24 1921
20 UNDERTAKER	**ADDRESS**
H. Sander & Sons	1710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51177

1200

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 W Henrietta ST.; 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Drummond

(a) RESIDENCE. NO. 406 Henrietta ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Drummond deceased

6 DATE OF BIRTH (month, day, and year) Jan 1, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 600

(b) General nature of industry, business, or establishment in which employed (or employer) Cleaning, Sandberg's

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maria Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Marie Matthews
(Address) 406 Henrietta

15 Filed FEB 24 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1920, to Feb 22, 1921, that I last saw h alive on February 21, 1921, and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

(duration) yrs. 2 mos. 18 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical, Regular

(Signed) M. D.

(Address) 1209 Presstman ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Feb 24 1921
20 UNDERTAKER	ADDRESS
A L Pinnell & Son	Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51178

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51178

CERTIFICATE OF DEATH.

REGISTERED NO. 5-79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Aisquith ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Edwards

(a) RESIDENCE. No. 207 Aisquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 93 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, ~~or Divorced~~ (write the word)
Female	colored	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	93			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 900

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary Hands
(Address) 207 Aisquith St

15 Filed FEB 24 1921 ROBERT I. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1920, to Feb 21, 1921, that I last saw h alive on Feb 20, 1921, and that death occurred, on the date stated above, at 10 60 m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J Edward Fisher M. D

2-23 1921 (Address) 1612 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Feb 24 1921
20 UNDERTAKER	ADDRESS
L L & J Bromwell Son	108 W Monty

IMPORTANT—Physicians will please fill out all items carefully and write plainly. Name of informant is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D51179

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

119-D51179

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1825 W. Baltimore ST. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John S. Moke

(Residence in Baltimore: No. 1825 W. Baltimore St.: 55 yrs. X mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	white	married

6-DATE OF BIRTH: 1 (Month) 30 (Day), 1854 (Year)

7-AGE: 67 yrs. X mos. 22 ds. If LESS than 1 day ..... hrs. or X min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House Builder
(b) General nature of industry, business, or establishment in which employed (or employer): 016

9-BIRTHPLACE (State or country): Balto Co. Md.

PARENTS

10-NAME OF FATHER: George Moke

11-BIRTHPLACE OF FATHER (State or country): Balto. Co. Md

12-MAIDEN NAME OF MOTHER: Hannah Kinsey

13-BIRTHPLACE OF MOTHER (State or country): Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Annie E. Moke

(Address) 1825 W. Balto. St

15- FEB 24 1921 Filed ..... 19.. ROBERT J. SLAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 2 (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/10/21, 191.., to, 2/22 1921, that I saw h[illegible] alive on 2/22 1921, and that death occurred, on the date stated above, at 7.50 p. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis and asthma

016

(Duration) 1 yrs. 1 mos. 2 ds

Contributory (SECONDARY) Uraemia from Acute Nephritis (Duration) 1 yrs. X mos. 4 ds.

(Signed), P. Wilson M. D.

2/23, 1921 (Address) 1124 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 25 1921
20-UNDERTAKER George J Smith	ADDRESS 1000 [illegible]

IMPORTANT—PHYSICIANS should NOTICE OF DEATH in plain terms, so that it may be stated EXACTLY. PHYSICIANS should is very important. See instructions on back of certificate. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51180

CERTIFICATE OF DEATH.

1082

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lola Varner

(a) RESIDENCE. No. New City Hosp. ST., WARD. Fairfield Balto Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col.	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Varner

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Frank Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Marie Chapman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant New City Hosp. Rec. (Address)

15 Filed FEB 24 1921 BOBERT J. SLAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21 1921 4 hrs

17 I HEREBY CERTIFY, That I attended deceased from 2-21, 1921, to 2-21, 1921, that I last saw h.er alive on 2-21-21, and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows: over

General Peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Septicemia & Bronchio-Pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) J. A. Holden, M. D.

, 19 (Address) New City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch a a C	FEB 24 1921
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	716 LIGHT ST.

TION is very important. See instructions on back of certificates.

it may be properly classified. Exact statement of OCCUPA-

PHYSICIANS should state in plain terms, so that

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer. Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Ruptured appendix
Streptococcus septicaemia

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 51181

1-PLACE OF DEATH St. Joseph's Hospital 31 REGISTERED NO.

CITY OF BALTIMORE: (NO. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Volpi

(a) RESIDENCE. NO. 3930 Claremont ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19-19[illegible]

7 AGE: Years: 1 Months: 8 Days: 14 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of Industry, business, or establishment In which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Frank Volpi

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Annie Libirgi

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant (Frank Volpi
(Address) 3930 Clairmont Ave

15 Filed FEB 24 1921 19.. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23. 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to Feb 23, 1921, that I last saw h.e.r. alive on Feb 23, 1921, and that death occurred, on the date stated above, at 4.15 p.m.

The CAUSE OF DEATH* was as follows:

Peritonitis - tuberculous

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Feb 23 1921

Was there an autopsy? no over

What test confirmed diagnosis? operative findings

(Signed) F. C. Marino, M. D.

2-23, 1921 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem

DATE OF BURIAL: Feby 20 1921

20 UNDERTAKER: J Herwig & Co

ADDRESS: 2008 Orleans

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pathological dislocated hip.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D5118 2 HEALTH DEPARTMENT—CITY OF BALTIMORE D51182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 91

CITY OF BALTIMORE: (No. 407 N Fremont St ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Cammarata

(a) RESIDENCE. NO. 407 N Fremont St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 18 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	~~1~~	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt md

PARENTS

10 NAME OF FATHER Thos Cammarata

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Sposa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rosa Cammarata
(Address) 407 N Fremont

15 Filed FEB 24 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1921, to Feb 23, 1921, that I last saw her alive on Feb 23, 1921, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of W

Was there an autopsy? N

What test confirmed diagnosis? None

(Signed) W W Yarnall M. D.

2-24-21 (Address) 117 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 24 1921
20 UNDERTAKER	ADDRESS
David Easton	916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other infection.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57183

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1921

CITY OF BALTIMORE: (No. 853 W. Lombard St. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Murray

(a) RESIDENCE. No. 853 W. Lombard St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida E. Murray

6 DATE OF BIRTH (month, day, and year): Dec. 25" 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	29	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work: Retired Reed Worker

(b) General nature of industry, business, or establishment in which employed (or employer): for Carriage & Toy

(c) Name of employer: Co.

9 BIRTHPLACE (city or town) (State or country): Montreal Canada

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Sophia Foisey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant: Mrs. Ida E. Murray
(Address): 853 W. Lombard St.

15 Filed FEB 24 1921 BOARD OF HEALTH Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 23" 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1921, to Feb 22, 1921 that I last saw him alive on Feb. 22, 1921, and that death occurred, on the date stated above, at 3.05 A.m.

The CAUSE OF DEATH* was as follows: DVH

Arterio-sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry H Weinberger, M. D.

. 19 (Address) 724 W Lafayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Feb. 26" 21

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 N. Balto Street

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51184

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Calhoun St. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Ann Derenberger

(a) RESIDENCE. No. 822 N. Calhoun St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Derenberger

6 DATE OF BIRTH (month, day, and year) Oct. 21" 1837

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
83	4	2	

8 OCCUPATION OF DEceased

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Finnigan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Patterson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Elizabeth Derenberger
(Address) 822 N. Calhoun St.

15 Filed FEB 24 1921, 19.. ROBERT J. BAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23" 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1921, to Feb. 23, 1921, that I last saw her alive on Feb. 22, 1921, and that death occurred, on the date stated above, at 12.40 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) Chas. C. McCarthy M. D.

19 (Address) 906 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 26 1921

20 UNDERTAKER J. B. Cook

ADDRESS 1003 E. Balto St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51185

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 Carroll St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Bell

(a) RESIDENCE. No. 1143 Carroll St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmira Bell

6 DATE OF BIRTH (month, day, and year) May 25" 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Fireman 032

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore Fire

(c) Name of employer Dept.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jehu A. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Elmira Bell

(Address) 1143 Carroll St.

15 Filed FEB 24 1921 19 MARK F. KRAUTH Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22" 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1921, to Feb 22, 1921, that I last saw him alive on Feb 21, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Edw Greenfield, M. D.

2/21 19.. (Address) 517 Scott

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Feb 25" 21

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 W. Balto St.

PLEASE WRITE PLAINLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 51186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51186

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH May 4

CITY OF BALTIMORE (No. Mercy Hospital from 113 N. Eden St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Meckler

(Residence in Baltimore: No. 113 N. Eden St.; yrs., ✓ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
f	w	S

6-DATE OF BIRTH, Dec 17, 1720
(Month) (Day) (Year)

7-AGE. 2 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, A. Meckler

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Katie Schulman

13-BIRTHPLACE OF MOTHER (State or Country), Katie Schuman

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Balto St

15- FEB 24 1921 WARD 5 HEALTH
Filed, 191.. Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage Coma Unknown probably

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. J. Riley M. D.
(Coroner.)
May 23, 1921 (Address) 1637 Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Northern Cem. DATE OF BURIAL, May 24, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto St

IMPORTANT. See instructions on back of certificate. Physicians should state causes of death in terms that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

25187 HEALTH DEPARTMENT—CITY OF BALTIMORE 25187

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 N. Payson St. 20 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. Heidemann

(a) RESIDENCE. No. 110 N. Payson St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): March 31, 1854

7 AGE — Years: 66 — Months: 10 — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo Merklin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: — Nash

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Mary S. Marley

(Address) 110 N. Payson St

15 Filed FEB 24 1921 19.. Registrar

Burial Permit 01655

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 21 1921

17 I HEREBY CERTIFY, that I attended deceased from Nov 2, 1920, to Feby 21, 1921, that I last saw h[illegible] alive on Feby 20, 1921, and that death occurred, on the date stated above, at 3.58 p.m.

The CAUSE OF DEATH* was as follows:

Acute Bright's Disease

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) M. A. O'Neill M. D.

2/23 1921 (Address) 108 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Feb 24 1921

20 UNDERTAKER: Geo Schwab & Bro — ADDRESS: 210 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-51188

D-51188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Padian

(a) RESIDENCE. No. None - except Mt Hope Retreat ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 0 mos. ds. How long in U. S., if of foreign birth? Not yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	75	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic (Former)

(b) General nature of industry, business, or establishment in which employed (or employer) Housework - Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) not known Ireland

PARENTS

10 NAME OF FATHER Jeremiah Padian

11 BIRTHPLACE OF FATHER (city or town) Roscommon (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Farrell

13 BIRTHPLACE OF MOTHER (city or town) Sligo (State or country) Ireland -

14 Informant Mount Hope Retreat (Address)

15 Filed FEB 24 1921 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 13-1911, 19..., to Feb. 23, 1921, that I last saw h er alive on Feb. 22, 1921, and that death occurred, on the date stated above, at 3.15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis - Post Pericarditis
With Fatty Degeneration -
abt (duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Dementia Senilis -
abt (duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Hill	2-26-21

20 UNDERTAKER MRS. M. E. FINK, LICENSED FUNERAL DIRECTOR 1895 W. PRATT STREET. ADDRESS

IMPORTANT. PHYSICIANS should state with all possible exactness the CAUSE OF DEATH, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 51189 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51189

CERTIFICATE OF DEATH.

REGISTERED NO. C 162

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 521 Cumberland St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Bull

(Residence in Baltimore: No. 521 Cumberland St. (yrs., 3 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1846 (Year)

7-AGE, 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, George Colbert

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Betz

(Address) 521 Cumberland St.

15- FEB 24 1921 ROBERT J. KRAUTER

Filed ....., 191.... Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 24 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. E. Radcliffe M. D.
(Coroner.)

2/23/21, 191... (Address) 1142 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Feb. 25, 1921
20-UNDERTAKER	ADDRESS
Martin Fahey & Son	1827 W. Baltimore St.

Instructions: PHYSICIANS should state name, if any, before abbreviations may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(See affadavit over)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51190

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51190

92-010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sarah F. Clabaugh 17 REGISTERED NO. .....

CITY OF BALTIMORE: (No. 2109 N. Charles ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Frances Wilson~~ Clabaugh

(a) RESIDENCE. No. 2109 N. Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Albert T Clabaugh

6 DATE OF BIRTH (month, day, and year): Sept 22 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: David Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Caroline Livergood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Albert T Clabaugh (Address) 2109 N. Charles St

15 Filed FEB 24 1921 ROBERT J. BRADER Burial Permit Clerk

3/4/1921 Geo. E. Greer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): ~~Feb 23~~ 2/23 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1921, to Feb. 23, 1921, that I last saw h~~e~~r alive on Feb 23, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Grippe

Lobar Pneumonia

(duration) — yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) Jefferis Bunn M. D.

1921 (Address) 2846 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Feb 25 1921
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Sons Co	Orchard & N. Collod

IT IS VERY important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state

GENERAL AFFIDAVIT — LUCAS BROS., INC., FORM 56

State of Maryland, Baltimore City, to wit:

BE IT REMEMBERED, *That on this* ----- 3rd *day of* March

A. D. 19 21 , *before me, the subscriber, a* Notary Public

of the said State, in and for the City aforesaid, personally appeared

Dr. Jefferies Buck, 2844 St. Paul Street, Baltimore, Md.,

and made oath in due form of law that

Frances Wilson Clabaugh, deceased, as written on death certificate, and Sarah F. Clabaugh, deceased, was one and the same person. Sarah F. Clabaugh died February 23rd, 1921. Her late residence was 3109 N. Charles St.,

...Jefferies Buck M.D.

Sworn and subscribed to before me this 3rd day of March, 1921.

Leo Engel

NOTARY PUBLIC
(My commission expires May 1, 1922).

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-5119 ✓ 91-079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-5119

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 839 Park Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Bosley Merryman

(a) RESIDENCE. No. 839 Park Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Ann Louisa Merryman

6 DATE OF BIRTH (month, day, and year) Feb 19 1852

7 AGE: Years 69 — Months — Days 5. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: John Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Ann Louisa Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ft Worling

14 Informant: Norton Merryman

(Address) Cockeysville Md

15 Filed FEB 24 1921 ROBERT I. CRATER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 15 1921, to Feby 24 1921, that I last saw him alive on Feby 23 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia —

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Endocarditis —

(duration) Many yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Physical diagnosis.

(Signed) Chas W Lazenby, M. D.

, 19 (Address) 132 W Mts, Baltimore —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sherwood Cem Co

DATE OF BURIAL: Feb 26 1921

20 UNDERTAKER: Henry J Jenkins & Son Co

ADDRESS: 1224 W Mc-Collough

Instructions on back of certificates. Exact statement of OCCUPA- should state properly classified.

Spec.—6-9-19.—H. P. Co.— 1000 Blks.

D 51192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51192

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 867 Vine ST.: 1828 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cordelia Fenderson

(a) RESIDENCE. No. 867 Vine ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed or divorced (or) WIFE of James Fenderson

6 DATE OF BIRTH (month, day, and year) Sep. 4, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Northampton Va

PARENTS

10 NAME OF FATHER George Jacob

11 BIRTHPLACE OF FATHER (city or town) (State or country) Northampton Va

12 MAIDEN NAME OF MOTHER Nellie Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Northampton Va

14 Informant James Fenderson (Address) 867 Vine St

15 Filed FEB 24 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 15, 1921, to Feby 22, 1921, that I last saw h alive on 2/21/1921, and that death occurred, on the date stated above, at 3.55 p m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. F. Hamilton, M. D.

2/23/1921 (Address) 767 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eastville Va Cape Charles Va	Feb 24 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

Important. See instructions on back of certificates. Exact statement of OCCUPATION should be given; if housewife, or housework, so state. Unless these items are properly classified.

Spec. 6-9-19 H. P. Co.—1000 Bks.

Harry E. Mullinix

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51193 D51193

10-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1700 Bell ST.: 24 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E Mullinix

(a) RESIDENCE. No. 1700 Bell ST., 24 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 5 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	5	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Albert Mullinix

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna Stonin

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Wm Mullinix
(Address) 1700 Bell St

15 Filed FEB 24 1921 ROBERT I. LEVY Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1921, to Feb 22nd 1921, that I last saw h. alive on Feb 22nd 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Influenza,

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Broncho)

Cardiac Failure (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis?

(Signed) T. O'Leonard, M. D.

2/23, 19 21 (Address) 29 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Private Mau	Feb 25 1921
20 UNDERTAKER	ADDRESS
W. W. Edwards & Son	Baltimore

Must be very important. See instructions on back of certificates. Cause of death may be properly classified. Exact statement of OCCUPATIONS should state

Spec.—8-24-14—M. & T.—2000 Bks.

D 51194

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51194

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 Moreland St.; 15 WARD)

REGISTERED NO. C 640

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna McCarthy.

(Residence in Baltimore: No. 1732 Moreland ave St.; 10 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March (Month), (Day), 1851. (Year)

7-AGE, 69 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Clark

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel J. McGarry

(Address) 1732 Moreland Ave

15-FEB 24 1921 ROBERT J. KRAUTER

Filed ....., 191.. Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 22 (Day), 1921. (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feby 22 1921, to Feby 22 1921, that I saw h[illegible] alive on Feby 22 1921, and that death occurred, on the date stated above, at 11.15 A.M.

The CAUSE OF DEATH* was as follows:

Apleuo-sclerosis

several (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage 5 hours.

(Duration) yrs. mos. ds.

(Signed) J. W. Brown M. D.

Feby 23 1921, (Address) 1935 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery — DATE OF BURIAL, Feby. 25, 1921.

20-UNDERTAKER Robt. Johnson — ADDRESS 1442 Broadway

Physicians should state specifically classified. Exact statement of OCCUPATION is very important.

See instructions on back of certificate.

D51195 Bertha Lott D51195

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C 184

CITY OF BALTIMORE (No. 1 Hebrew Orphan St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Lott

(Residence in Baltimore: No. 2105 Eagle St St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, aug — (Month) (Day), 1897 (Year)

7-AGE, 24 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Abe Silberman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rachael Weinstein

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morris Lott

(Address) 2043 Wilkens Ave

15- FEB 24 1921 Filed ..... 191... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Stomach Ill

Mother (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Irvine Gaulay M. D.
(Coroner.)

; 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Orphan Asy — DATE OF BURIAL, Feb 26, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

Exact statement of OCCUPATION is very

...on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51196

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12nd N. Durham St. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Holler

(a) RESIDENCE. NO. 2638 E. Monument. ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Valentine Holler.

6 DATE OF BIRTH (month, day, and year) Dec. 18-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Market.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalene Feuchsmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Hannah Brickner
(Address) 2638 E. Monument St.

15 FEB 24 1921 BOREN & FRAZER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1921, to Feb 22, 1921, that I last saw h[illegible] alive on Feb 21, 1921, and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) ... yrs. ... mos. 28 ds.

CONTRIBUTORY (Secondary) Progressive Cardiac Asthenia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Edward J. Levi C, M. D.

2/23 1921 (Address) 413 N. Washington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Feb 25 1921
20 UNDERTAKER Lilly & Zeiler.	ADDRESS 403 S. Mus[illegible]

IMPORTANT. PHYSICIANS should state fully and correctly all the items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51197 HEALTH DEPARTMENT—CITY OF BALTIMORE D51197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital St. 25 Ward) REGISTERED NO.

2-FULL NAME Baby Smedley

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. St. Agnes Hospital St., Ward. 1912 Harlem Ave

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				2 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of Industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Agnes Hosp.

PARENTS

10 NAME OF FATHER Bedford Smedley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Bedford Smedley
(Address) 1912 Harlem Ave. City

15 Filed ..... 19 Robert P. Harrison, Registrar

FEB 24 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-22 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-22, 19 21, to 2-22, 19 21, that I last saw h[illegible] alive on 2-22, 19 21, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature Labor
1 mos.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dudley A. Bowe, M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Feb 24 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Mon.

Fee

Spec.—8-24-14—M. & T.—2000 Bks.

20.51198 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51198

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Eastland Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Simanek

(Residence in Baltimore: No. 1908 Eastland Ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ... Aug 8 1861 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
59 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Kalal

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Anna Base

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Simanek

(Address) 1908 Eastland Ave

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

341921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 22, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Jan 22 1921, that I saw h[illegible] alive on Jan 22 1921, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Valvular Heart Disease

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Jan 25, 1921

20-UNDERTAKER Frank Brach & Son ADDRESS 1906 Eastland Ave

(1) Instructions on back of certificate. (2) Exact statement of OCCUPATION is very important and should be properly classified.

D.51199 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51199

CERTIFICATE OF DEATH.

175-003

1-PLACE OF DEATH Md Genl Hospital

CITY OF BALTIMORE (No. 2 ST.: WARD) REGISTERED No. C.....

2-FULL NAME Adam Pyglik

(Residence in Baltimore: No. 314 S Ann St. (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	White	Single

6-DATE OF BIRTH. Dec (Month) 30 (Day), 1902 (Year)

7-AGE. 18 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Riveter 086
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Alexander Pyglik

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Rozalia Galanek

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rozalia Pyglik

(Address) 314 S Ann St

15- Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

3-24-1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2- (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull Accident

(Duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Shocks

(Duration) yrs. mos. ds.

(Signed) Jas Collins Blake M. D.
(Coroner.)

2/24/21, 191... (Address) 1437 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, Feb 26, 1921

20-UNDERTAKER John N Weber ADDRESS 1803 Bank St

Should state OCCUPATION is very

Exact statement of

PHYSICIANS

property classified.

on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.51200 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51200

CERTIFICATE OF DEATH.

6 29

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N. Durham ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Byron Leroy Hooper

(a) RESIDENCE. NO. 217 N. Durham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 900

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Hilda Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mother, Hilda Hooper
(Address) 217 N. Durham St

15 Filed 2 4 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1921, to Feb 18, 1921, that I last saw him alive on Feb 18, 1921, and that death occurred, on the date stated above, at 10.30 A.m.

The CAUSE OF DEATH* was as follows:

Generalized Miliary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) James C. Fox Jr. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Feb 25 1921
20 UNDERTAKER	ADDRESS
Milton Davis.	413 N Eden St

TION is very important. See instructions on b... should state ... OCCUPA... ...ll may be properly classified. Exact statement ... ...s on back of certificates.

D. 51201 — Hom Bow — D. 51201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 9 184

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 110 Josh Hospital St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hom. Mow

(Residence in Baltimore: No. 2465 Greenmount Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Chinese

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 51 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundryman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 041

9-BIRTHPLACE, (State or Country), China

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Claude Mow Hom

(Address) 328 Park Ave

15-

Filed ....., 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 22, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by blows inflicted on head, (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) C. Ross Donaldson M. D.
(Coroner)

2-22, 191.7. (Address) 7 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemy

DATE OF BURIAL, Mch 25, 1917

20-UNDERTAKER J O'Mitchell

ADDRESS 1201 W Fay Ave

Duplicate of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 51202

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51202

CERTIFICATE OF DEATH.

X 137

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.) (WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Cochran

(a) RESIDENCE. No. Fallston Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Cochran

6 DATE OF BIRTH (month, day, and year): Jan 26-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~30~~	31	✓	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co Md.

PARENTS

10 NAME OF FATHER: Owen Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md.

12 MAIDEN NAME OF MOTHER: Mary Golden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Owen Murphy Harford Co Md.

15 Filed FEB 24 1921 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1921, to Feb 24, 1921, that I last saw h[er] alive on Feb 24, 1920, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis Hypertensive Heart Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home ?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) [illegible], M. D.

(Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hickory Cem. Harford Co - Md	Feb. 26 1921
20 UNDERTAKER: Wm. J. Tickner & Sons	ADDRESS: N. Va.

IT IS IMPORTANT. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Developed 3 wks after child birth. Probably puerperal.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51203

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 N. Washington ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicklas Zullinger

(Residence in Baltimore: No. 226 N Washington St.; 61 yrs., 8 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, June (Month) 11 (Day), 1860 (Year)

7-AGE, 61 yrs. 8 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer 086
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Nicklas Zullinger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Reese

(Address) 216 N. Washington St

15- Robert P. Harrison,

Filed 4 1921 191

B 54 1921 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb (Month) 22 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 13 1921, to Feb 22 1921, that I saw h— alive on Feb 21 1921, and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

Endocarditis (Duration) 7 yrs. mos. ds.

(Signed) Wm 13 Lemmon M. D.

2/24, 1921. (Address) 718 N Patterson Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State 61 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Feb. 25, 1921.

20-UNDERTAKER Geo Leimbach & Son

ADDRESS 647 W Pratt St

Important. See instructions on back of certificate.

...PHYSICIANS should state ...exactly. Exact statement of OCCUPATION is very ...may be properly classified. ...so that it

D. 51204 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51204

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1505 E. Lafayette Ave St.; 8 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Lusby.

(Residence in Baltimore: No. 1505 E. Lafayette Ave St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Widower

6-DATE OF BIRTH, September 26, 1846
(Month) (Day) (Year)

7-AGE, 74 yrs. 5 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): 078

9-BIRTHPLACE, (State or Country), Balto - Md.

PARENTS.

10-NAME OF FATHER, Wm. Lusby.

11-BIRTHPLACE OF FATHER (State or Country), Balto - Md

12-MAIDEN NAME OF MOTHER Mary A. Adams.

13-BIRTHPLACE OF MOTHER (State or Country), Balto - Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Lusby

(Address) 1505 E. Lafayette Ave

15-

Filed 2-24, 191

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 24, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

2-24, 191 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Feb 28, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E. North Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 lbs.

(See affidavit over)

D.51205 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51205

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2442 Frederick St. Ave (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. 716yers

(a) RESIDENCE. No. 2442 Frederick St. Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Cornelius 716yers

6 DATE OF BIRTH (month, day, and year) aug 8 = 1856

7 AGE: Years 74 ~~64~~ Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Williams 26- 716yrs
(Address) 104 South Chester

15 Filed 19 Robert F. Harrison,
Registrar
41921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 22nd, 19 20, to Feb 22nd, 1921, that I last saw alive on Feb 22nd 21, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dey Dockery, M. D.

(Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: 2-24 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E North

Instructions on back of certificates. Exact statement of OCCUPA-

Baltimore, Md., March 15, 1921.

I do hereby make oath that the age given on Baltimore City Health Department Death Certificate No. D. 51205, as 64 years, 6 m is not correct, and that same should be 74 years, 6 months.

Wm. H. Myers

Subscribed and sworn to before me this 15th day of March, 1921

Red Cathe

Spec.—8-24-14—M. & T.—2000 Blks.

D.51206

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51206

CERTIFICATE OF DEATH.

REGISTERED No. C 9 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 E. North Av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lambert W Partridge

(Residence in Baltimore: No. 924 E. North Av St.; 70 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 30 (Day), 1845 (Year)

7-AGE, 75 yrs. 11 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist O.S.T.
(b) General nature of industry, business, or establishment in which employed (or employer): Foreman

9-BIRTHPLACE, (State or Country), Howard County Md

PARENTS.

10-NAME OF FATHER, Wm Partridge

11-BIRTHPLACE OF FATHER (State or Country), Howard County Md

12-MAIDEN NAME OF MOTHER, Cassandra Clark

13-BIRTHPLACE OF MOTHER (State or Country), Howard County Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Little

(Address) 531 N Fremont Av

15-

Filed Robert P. Harrison, Registrar.

B34192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 24 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from JAN 7 1921 191..., to FEB 23 1921, that I saw h IM alive on FEB 23 1921, and that death occurred, on the date stated above, at 11.40 m.

The CAUSE OF DEATH* was as follows:

Dilated heart

..... (Duration) 1 yrs. X mos. Dk ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

..... (Duration) 5 or more yrs. ... mos. ... ds.

(Signed) O H Duker M. D.

FEB 24 1921, 1921 (Address) 928 E North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Feb 26, 1921.

20-UNDERTAKER Geo W Little

ADDRESS 531 N Fremont Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

No. 51207 HEALTH DEPARTMENT—CITY OF BALTIMORE No. 51207

V

10-091

CERTIFICATE OF DEATH.

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Wilkens ave e/b ST., 25 WARD)

2-FULL NAME Anna A. Stroeker

(a) RESIDENCE. No. Wilkens ave e/b ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? 51 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry S Stroeker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Adelaide Kusterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo A Brack
(Address): Wilkens Ave E/b

15 Filed 19 Robert P. Harrison, Registrar

B24 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 10, 1921, to Feby 23, 1921, that I last saw her alive on Feby 22, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pneumonia (Broncho)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) P. G. Dill M. D.

2/23 1921 (Address) 1433 Lombard E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
Baltimore	Feb 26 1921
20 UNDERTAKER: Geo W Little	ADDRESS: 531 N Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51208 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 Edmondson av ST.; 16 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George C. Harris

(Residence in Baltimore: No. (46 years) 1030 Edmondson av St.; 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, June (Month) 17 (Day), 1854 (Year)

7-AGE, 66 yrs. 8 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Merchant Tailor
(b) General nature of industry, business, or establishment in which employed (or employer). 080

9-BIRTHPLACE, (State or Country). Cambridge Md

PARENTS.

10-NAME OF FATHER. Isaac Harris

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Emily Spedden

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Little

(Address) 531 N Fremont Av

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

2 4 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 24th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from about Feb 10th 1921, to Feb 20 1921, that I saw him alive on Feb 23rd 1921 and that death occurred, on the date stated above, at about 2a m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

about

6 mo. or 1/2 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis the above

(Duration) yrs. mos. ds.

(Signed) John T. Mason M.D. M. D.

Feb 24, 1921 (Address) 1008 E Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, Feb 26, 1921.

20-UNDERTAKER Geo W Little

ADDRESS 531 N. Fremont Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51209

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Bon Secours Convent. ST.: // WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabel Clara Steuart.

(a) RESIDENCE. No. 839 Park Av. ST. 11 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 79 yrs. 4 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (None)

6 DATE OF BIRTH (month, day, and year) October-23-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. ppm

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer None.

9 BIRTHPLACE (city or town) (State or country) West River, Maryland.

PARENTS

10 NAME OF FATHER Dr. Rich'd. S. Steuart

11 BIRTHPLACE OF FATHER (city or town) West River (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maria deBernabeu

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country) Spain.

14 Informant Miss Frances Steuart (niece)
(Address) 2001 N. Calvert St. City.

15 Filed FEB 25 1921 19 ... Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from ..., 19 05, to Feb. 20th, 19 21, that I last saw h... alive on Feb. 20th, 19 21, and that death occurred, on the date stated above, at 12 2 m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration.

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 50 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? None by Clinic & Signs

(Signed) J. A. Chatard, M. D.

Feb. 23rd 1921 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Feb-25-1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

...back of certificates. Exact statement of OCCUPA-... See instructions on back ... properly furnished.

Form.—6-9-19—H. P. Co.—1000 Bks.

D 51210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51210

CERTIFICATE OF DEATH.

15-79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4000 Garrison Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Oakford Tormey.

(a) RESIDENCE. No. 4000 Garrison Av. ST., 15 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? 44 yrs. 1 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alfred Jenkins Tormey

6 DATE OF BIRTH (month, day, and year) Jan-18-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 037

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer None.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Chas. A. Oakford.

11 BIRTHPLACE OF FATHER (city or town) Yonkers,
(State or country) New York.

12 MAIDEN NAME OF MOTHER Emma A. Zollinger

13 BIRTHPLACE OF MOTHER (city or town) Harrisburg
(State or country) Pennsylvania.

14 Informant Alfred J. Tormey (husband)
(Address) 4000 Garrison Av.

15 Filed FEB 25 1921 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1920, to Feb 23rd, 1921, that I last saw her alive on Feb 22nd, 1921, and that death occurred, on the date stated above, at 6 o'c a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (Subacute)
(Streptococcus Viridans.)

(duration) yrs. 7 mos. ? ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Symptoms, Signs and Blood Culture

(Signed) Jas. Chatard, M. D.

Feb 23rd, 1921 (Address) 820 N. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Feb-25-21

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Exact statement of OCCUPA-

See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51211 HEALTH DEPARTMENT—CITY OF BALTIMORE D51211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 N. Ann. ST.; 6 WARD) REGISTERED NO. 64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Fry.

(a) RESIDENCE. No. 211 N. Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer): at home. 00

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Fry.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER Martha Hussey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Imogene Fry.
(Address) 211 N. Ann st.

15 Filed FEB 25 1921 ROBERT S. BRAUER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1921, to Feb. 24, 1921, that I last saw her alive on Feb. 24, 1921, and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Obvious symptoms

(Signed) G. G. Penk, M. D.

, 19 (Address) 1201 N. Chas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feby 26th 1921

20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Balto St.

IMPORTANT. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—2000 Bks.

D51212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51212

156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 719 S. Lakewood ave ST.: 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Marie Berends

(a) RESIDENCE. No. 719 S. Lakewood av ST., 1st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 21-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Oscar E. Berends

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Helen Teller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Oscar Berends

(Address) 719 S. Lakewood ave

15 Filed FEB 25 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1921, to Feb. 23, 1921, that I last saw h[illegible] alive on Feb 23, 1921, and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. ds.

Large Boil on Back, which ruptured at birth

CONTRIBUTORY (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. J. Long, M. D.

2-24 1921 (Address) 2701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Cem.	2-25-1921
20 UNDERTAKER	ADDRESS
J. A. Moran	E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51213 HEALTH DEPARTMENT—CITY OF BALTIMORE D51213

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 134 Calverton Rd ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Benjamin Ray

(a) RESIDENCE. No. 134 Calverton Rd ST. 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 24- 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none ooo

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas B Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lillian M McClure

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas B Ray

(Address) 134 Calverton Rd

15 Filed FEB 25 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1921, to Feb 24, 1921, that I last saw ~~him~~ alive on Feb 24 - 1921 and that death occurred, on the date stated above, at 10.05 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia ooo

..... (duration) ..... yrs. ..... mos. 28 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ~~[illegible]~~

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C Miller Hemming M. D.

2/27/1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 26 1921
20 UNDERTAKER	ADDRESS
Geo. W. Schmidt & Bro	2101 Pratt St

Important. See instructions on back of certificates. ... may be properly classified. Exact statement of OCCUPATIONS should state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior to pneumonia.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51214 D51214

CERTIFICATE OF DEATH.

REGISTERED NO. C 105

1-PLACE OF DEATH W.

CITY OF BALTIMORE: (No. 411 Dasalyga st ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice G Meyer

(Residence in Baltimore: No. 411 Dasalyga st St.; 68 yrs., 4 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 9 (Day) 1852 (Year)

7-AGE, 68 yrs. 4 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home duties
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Goldsborough

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laurence Meyer

(Address) 411 Dasalyga st

15- FEB 25 1921 Filed ....., 191.... BORIS D. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby (Month) 23 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1920, to Feby 23 1921, that I saw h[illegible] alive on Feby 23 1921, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

a Cerebral Hemorrhage

General Broken down

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Drunkard

(Duration) ....yrs....mos. 8 ds.

(Signed) C. K. Davis M. D.

....., 191... (Address) 1108 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Feb 26, 1921

20-UNDERTAKER George L Schwab & Bro — ADDRESS 1101 Eutaw Av

D 51215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51215

CERTIFICATE OF DEATH.

8-091

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2615 Fleet ... St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Kurathowski

(Residence in Baltimore: No. 2615 Fleet St

St. 9 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, November 13, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md U S A

PARENTS.

10-NAME OF FATHER, Joseph Kurathowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Francis Slowinska

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md U S A

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Kurathowski

(Address) 2615 Fleet St

15- FEB 25 1921 ROBERT J. KRAUTER

Filed....., 191.... Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 24, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchi Pneumonia

..... (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Whooping Cough

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Thomas Lynn Austin M. D.
(Coroner)

Feb 25, 1921. (Address) 1708 Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem — DATE OF BURIAL, Feb 26, 1921

20-UNDERTAKER Stephen J. Fialkowski — ADDRESS 1000 S Kenwood Ave

Directions on back of certificate. Exact statement of OCCUPATION is very important. Physician should state

Spec. 6-9-19—H. P. Co.—1000 Bks.

D51216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51216

CERTIFICATE OF DEATH.

1 91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3122 Dillon ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mc Gainey

(a) RESIDENCE. No. 3122 Dillon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 28/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Mc Gainey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Edith Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Edith Mc Gainey 3122 Dillon

15 Filed FEB 25 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 24 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/21, 1921, to 2/23, 1921, that I last saw h[illegible] alive on 2/23/21, 19, and that death occurred, on the date stated above, at 11A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) No previous infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. McGarrell, M. D.

1921, (Address) 633 S-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	2/26 1921
20 UNDERTAKER Philip Herwig	ADDRESS 206 Orleans

Should state very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D51217 HEALTH DEPARTMENT—CITY OF BALTIMORE D51217

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2145 N. Lexington St.; 20 WARD) REGISTERED No. C 50

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME M. Libetta Jones

(Residence in Baltimore: No. 2145 N. Lexington St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Mar. (Month) 23 (Day), 1846 (Year)

7-AGE, 74 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Thomas R Jones

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER, Susanna Keller

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Jones

(Address) 2148 N. Lexington St

15- ROBERT J. KRAUSE

Filed FEB 25 1921 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-1 1920, to 2-23 1921, that I saw him alive on 2-20 1921, and that death occurred, on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene R. foot

(Duration) yrs. mos. 3 ds.

(Signed) Wm F Bryant M. D.

2-24-, 191 2. (Address) 1225 Madison Ave Balto.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. moc. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet Balto Co | DATE OF BURIAL Feb 25, 191

20-UNDERTAKER H. S. Marshall | ADDRESS 3539 Fait Ave

Fill out statement of OCCUPATION is very important. Exact statement of OCCUPATION is very necessary to form basis of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D51218 HEALTH DEPARTMENT—CITY OF BALTIMORE D51218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST.; 20 WARD) REGISTERED No. C 127

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Louis Potlack

(Residence in Baltimore: No. 1917 Wilkens ave St.; yrs., mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Jewish

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Jan 7, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Baltimd

PARENTS.

10-NAME OF FATHER, Abe Potlock

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Gertie Bors

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Baltd St

15- FEB 25 1921 ROBERT J. KRAUTER Registrar of Vital Statistics

Filed ....., 191.... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 23, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~Feb 23~~ Feb 23, 1921, to Feb. 23, 1921, that I saw him alive on Feb. 23, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Exsanguination (Anemia following) Circumcision

(Duration) ....yrs. ....mos. 27 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward J. Levy M. D.

2-23, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. 27 ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rock Road

DATE OF BURIAL, 2-25, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt St

IMPORTANT. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 51219 Benjamin Lazarovitz D 51219

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (See affidavit over) REGISTERED No. C

CITY OF BALTIMORE (No. 3394 N. Dav ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Lazarovitz

(Residence in Baltimore: No. 2804 Hilldale Ave 25 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... October 24 1866
(Month) (Day) (Year)

7-AGE, 51 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Self

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Benjamin Lazarovitz

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Dinah Lazarovitz

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Baltimore St.

15-

Filed FEB 25 1921 191.. ROBERT S. KRAUTER

Burial Permit Issued 2/24/1921 G.H. Gross Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb 24 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... None .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... None .....
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage
Contributory Pneumonia

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... Wesley (Coroner.) ..... M. D.

Feb 24, 1921 (Address) 1607 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Lebanon Cemetery DATE OF BURIAL, Feb 25, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Baltimore St

If may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

5129

STATE OF MARYLAND, CITY OF BALTIMORE, to wit:

I HEREBY CERTIFY that on this 7th day of March, nineteen hundred and twenty-one, before me, the subscriber, a Notary Public of said State, in and for the City aforesaid, personally appeared Nathan Lazarowitz, son of Benjamin Lazarowitz, late of Baltimore City, deceased, and he made oath in due form of law that on Thursday, February 24, 1921, his said father, Benjamin Lazarowitz, died, and that on said date, Coroner W. T. Riley, investigating the cause of death, asked him, the said Nathan Lazarowitz, the age of his father, and that in his excitement, the said Nathan Lazarowitz, incorrectly gave the age of his father as Sixty-five years; and he further made oath that the correct age of his father is unkown to himself or to his mother, wife of said deceased, or is said age known to anyone of his kin, and further that his father did not himself know exactly how old he was; and the said Nathan Lazarowitz further made oath that he believes that his father's age was approximately fifty-one years, at the time of his death.

Nathan Lazarowitz

SUBSCRIBED and sworn to before me, this 7th day of March, 1921.

Louis A. Schwartz
Notary Public.

Jeannette Feuss.

Rev. 6-9-19—H P. Co.—1000 Blks.

D51220 HEALTH DEPARTMENT—CITY OF BALTIMORE D51220

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland General Hospital. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanette Feuss.

(a) RESIDENCE. No. 1700 London Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widowed.

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of Andrew C. Feuss

6 DATE OF BIRTH (month, day, and year) March 7-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia.
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER F W Duckstein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Lawrence

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Denmark

14 Informant Allen E Feuss
(Address) 1700 London Ave

15 Filed FEB 25 1921 ROBERT B ARMSTRONG Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23 1921

17

I HEREBY CERTIFY, That I attended deceased from February 2, 1921, to Feb 23, 1921, that I last saw h[illegible] alive on Feb. 23, 1921, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Caecum

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At residence

Did an operation precede death? Yes · Date of 2/21/21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Fred J. Baumgartner M. D.

2/23, 1921 (Address) Maryland General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Feb 25 1921
20 UNDERTAKER	ADDRESS
Chas. E. Franck	801 Madison Ave

IMPORTANT: PHYSICIANS should state IT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51221

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51221

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 N. Carrollton ave ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Hutson

(a) RESIDENCE. NO. 1122 Carrollton ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Baltimore 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
76	1845	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) M. C.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Lena Bright
(Address) 1122 N. Carrollton

15 Filed FEB 25 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24 1921

17 I HEREBY CERTIFY, That I attended deceased from 10/17, 1920, to 2/24, 1921, that I last saw h. ALIVE on 2/23, 1921, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Auto Toxemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 6 mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. H. Thompkins M. D.

2/25, 1921 (Address) 1014 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	Feb 26 1921
20 UNDERTAKER	ADDRESS
Jas. H. Chase & Son	1400 Madison

Instructions on back of certificates. Exact statement of OCCUPATION should be properly classified.

D51222 HEALTH DEPARTMENT—CITY OF BALTIMORE D51222

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 653 W. Mulberry ST. 4 WARD) REGISTERED No. C 79

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Taylor

(Residence in Baltimore: No. 653 W. Mulberry St.; 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... Don't Know ..... 1 .....
(Month) (Day) (Year)

7-AGE, 54 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Della Greene

(Address) 653 W. Mulberry

15- FEB 25 1921 ROBERT A. GARTER
Filed ....., 191.... Burial Permit Issued
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb. 23., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Valvular disease of the Heart .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... H. P. Grenet ..... M. D.
(Coroner.)

2-24, 1921 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Feb. 26, 1921

20-UNDERTAKER Wm. H. Chrestin — ADDRESS Woodlawn

Sec. 5 of Ordinance of 1915 requires that PHYSICIANS should state the primary cause of death properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D51223 HEALTH DEPARTMENT—CITY OF BALTIMORE D51223

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1811 Mc Henry ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert McGee

(Residence in Baltimore: No. 1811 Mc Henry St.; yrs. 2 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Dec 24, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Joseph McGee

11-BIRTHPLACE OF FATHER (State or Country), Balto city.

12-MAIDEN NAME OF MOTHER Elliott Kidd

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lew McGee

(Address) 1823 Mc Henry St

FEB 25 1921

Filed....., 191.. Burial Permit Clerk.

WHEN A REQUIRED Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 24, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration).....yrs.....mos. 10 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) James M Fenton M. D.
(Coroner.)

Feb 24 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Feb 25, 1921

20-UNDERTAKER Harry H. Witzke

ADDRESS 531 W Lombard

PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important. Information on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D51224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51224

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 N. Arlington Ave. St.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola Inez Williams

(Residence in Baltimore: No. 235 N. Arlington Ave. St.; yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, Dec. 2 1921, 1
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. ....ds. | If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Richard Williams

11-BIRTHPLACE OF FATHER (State or Country), Country

12-MAIDEN NAME OF MOTHER Dora Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Williams

(Address) 235 N. Arlington Ave

15-

Filed FEB 25 1921, 191.... ROBERT P. BRUTER
CHIEF CLERK
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 16 1921, to Feb. 23 1921, that I saw her alive on Feb. 16 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) ....yrs. ....mos. 1 Wk. ds.

(Signed) W. V. Carr M. D.

Feb. 23, 1921 (Address) 5 N. Mosher St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters | DATE OF BURIAL, Feb. 24, 1921

20-UNDERTAKER James H Dennis | ADDRESS 1303 Pennsylvania

Directions on back of certificate. Exact statement of OCCUPATION is very properly classified. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~#10~~ 25 1225 — 014 — 25 1225

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Carter.

(a) RESIDENCE. No. 1519 Prestman St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ Life ~~mos.~~ ~~ds.~~ How long in U. S., If of foreign birth? yrs. 4 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Josephine Johnson (mother)

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1920

7 AGE — Years: — Months: 4 — Days: 26 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. ~~fool~~

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Carter.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Josephine Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: J. H. hosp. records

(Address): .....

15 FEB 25 1921 — [illegible] Registrar — Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1921, to Feb. 22, 1921, that I last saw her alive on Feb. 22, 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary): Bacillary Dysentery Flexner

(duration) — yrs. — mos. 9 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? cultures & X ray

(Signed) [illegible] M. D.

, 19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL: Feb 24 1921

20 UNDERTAKER: James H Dennis — ADDRESS: 1303 Prestman

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Spaces must be filled in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D51226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 Patapsco ave ST.; Brooklyn WARD) 25

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leona Gant

(Residence in Baltimore: No. 511 Patapsco ave St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug (Month) 31 (Day), 1919 (Year)

7-AGE, 1 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Washington DC

PARENTS.

10-NAME OF FATHER, Max L. Gant

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lylen Amelia V. Lockyer

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Max L. Gant

(Address) Brooklyn Md

15- FEB 25 1921 Filed....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 24 1921, to Feb 25 1921, that I saw her alive on Feb 24 1921, and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Croup (Spasmodic)

30 (Duration) ....yrs....mos....ds.

(Signed) Chas N. Brooke M. D.

Feb 25, 1921. (Address) Brooklyn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Washington DC.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Feb 28 1921
20-UNDERTAKER John F. Denny	ADDRESS 715 Light St

Property examined. Exact statement of OCCUPATION is very important. PHYSICIANS should state cause of death on back of certificate.

Remarks .....

Phy. states emphatically not diphtheretic

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51227

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51227

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 N. Bradford ST.; 6 WARD)

REGISTERED NO. 119

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Cook

(a) RESIDENCE. No. 105 N. Bradford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Cook

6 DATE OF BIRTH (month, day, and year): Feb 5, 1851

7 AGE — Years: 70 — Months: — Days: 17 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): 004
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frederick Cook
(Address): 105 N. Bradford

15 Filed FEB 25 1921 ROBERT J. BRAGER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1921, to Feb 22, 1921, that I last saw h alive on Feb 22, 1921, and that death occurred, on the date stated above, at 6.55 A m.

The CAUSE OF DEATH* was as follows:

acute Nephritis

0730

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Uremic Coma

Exhaustion (duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Wade, M. D.

Feb 24 1921 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Matthews — DATE OF BURIAL: Feb 25 1921

20 UNDERTAKER: Zickler & Zickler — ADDRESS: 1739 Eager

ATION is very important. See instructions on back of certificates. ...ate may be properly classified. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D5128 HEALTH DEPARTMENT—CITY OF BALTIMORE D57228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Argyle ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Eugene Hensley

(a) RESIDENCE. No. 1217 Argyle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26, '21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Harry Hensley

11 BIRTHPLACE OF FATHER (city or town) Charles Co. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Fitch

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.
(State or country)

14 Informant Anna Hensley
(Address) 1217 ~~Pacas~~ Argyle Ave

15 Filed ....., 19.... ROBERT J. [illegible]
FEB 25 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1921, to Feb 24, 1921, that I last saw h— alive on Feb 24, 1921, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis - Sequel of Scarlatina.

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Scarlatina

(duration) ....yrs. ....mos. 18 ds.?

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Culture negative for Diphtheria - Clinical from the time

(Signed) Wm Harvey Hess, M. D.

(Address) 1709 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Owensville Md	Feb 25 '21
20 UNDERTAKER	ADDRESS
Daniel Easton	Do

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATIONS should state what is very important. Exact statement of OCCUPATIONS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51229 HEALTH DEPARTMENT—CITY OF BALTIMORE D51229

CERTIFICATE OF DEATH Gardenville 29

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Blair Road and Southern Ave. St.; 29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Weilbenner

(a) RESIDENCE. No. Blair Road and Southern Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Weilbenner

6 DATE OF BIRTH (month, day, and year) Dec. 16th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	2	6	

8 OCCUPATION OF DECEASED 0.86

(a) Trade, profession or particular kind of work Roads Superviser

(b) General nature of industry, business, or establishment in which employed (or employer) Highways

(c) Name of employer Balto. Co.

9 BIRTHPLACE (city or town) Bavarian (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Weilbenner

11 BIRTHPLACE OF FATHER (city or town) Bavarian (State or country) Germany.

12 MAIDEN NAME OF MOTHER Katherine Solm

13 BIRTHPLACE OF MOTHER (city or town) Bavarian (State or country) Germany.

14 Informant Annie M. Weilbenner (Address) Carlenville Md.

15 Filed ....., 19 ROBERT J. KRAUTER Registrar

FEB 25 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1921

17 I HEREBY CERTIFY that I attended deceased from Feby 1 1921, to Feby 22 1921, that I last saw h.....alive on ....., 19....., and that death occurred, on the date stated above, at 8:40 a. m.

The CAUSE OF DEATH* was as follows: Valvular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Harold Brose, M. D.

, 19 (Address) Gardenville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	Feb 27 1921
20 UNDERTAKER	**ADDRESS**
Fred'k Lassahn & Sons	Fiderton Md.

Property classified. Exact statement of OCCUPATION should state ... See instructions on back of certificates.

Form —6-9-18—H. P. Co.—1000 Bks.

92-119

D51230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Anthony Ave. near Franklin Ave (ST.) Raspeburg (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C. Carroll Sweglar

(a) RESIDENCE. (Usual place of abode) No. Anthony Ave. near Franklin Ave ST. Raspeburg WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30th 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamfitter Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Heat & Power Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph P. Sweglar

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine E. Bishop

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Katherine Sweglar (Address) Raspeburg Md.

15 Filed FEB 25 1921 ROBERT J. BRAUER Registrar

Burial Permit Oiled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1921, to Feb 24, 1921, that I last saw him alive on Feb 24, 1921, and that death occurred, on the date stated above, at 2.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. A. Woodward, M. D.

(Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feb. 28 1921

20 UNDERTAKER	ADDRESS
Heath Lassahn & Sons	Fiderton Md

Instructions on back of certificates. Exact statement of OCCUPATION

Misc.—6-9-19—H. P. Co.—1000 Bks.

D51231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51231

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 Cathedral ST.: 11 WARD) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Fittings

(a) RESIDENCE. No. Maryland Club Charles Keyser Sts SE corner ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) to not know 1860,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James Fittings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. County

12 MAIDEN NAME OF MOTHER Mary Ellis Mcgill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md.

14 Informant Mrs. H. Irving Reid (Address) 608 Cathedral St.

15 Filed FEB 25 1921 [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Last rec'd of Deft., 1914, to 2-4-21, 1921,

that I last saw him alive on 2-4-21, 1921,

and that death occurred, on the date stated above, at 4.20 a. m.

The CAUSE OF DEATH* was as follows:

Paretic dementia & Locomotor ataxia Combo-spinal Syphilis — Recvd within a year

(duration) 21 yrs. mos. ds.

CONTRIBUTORY (Secondary) diabetes mellitus

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Thorough exam'n for two years

(Signed) C. E. Thayer, M. D.

, 19 (Address) 406 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Feby 26 1921
20 UNDERTAKER	ADDRESS
John B Spence	1325 N. Carolina St

See instructions on back of certificates. Exact statement of OCCUPA- should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ortmueller.

D 57232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57232

CERTIFICATE OF DEATH.

15-110

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2306 - Roslyn ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ortmueller

(a) RESIDENCE. No. 2306 Roslyn ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. - 20 - 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mfg. 04

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs. P. Ortmueller

(Address) 2306 - Roslyn

15 Filed FEB 25 1921 ROBERT J. BRAUER Registrar Burial Permit Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. - 23. - 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby - 20, 19 21, to Feb. 23 - , 19 21, that I last saw him alive on Feby - 20, 19 21, and that death occurred, on the date stated above, at 6-P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
arteriosclerotic.
(No evidence of Malignancy)

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) — yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

, 19 (Address) 2707 Monson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 26 1921

20 UNDERTAKER Josiah Seyfert & Son

ADDRESS North Ave

Important. See instructions on back of certificates. Should state properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51233

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Franklin Ter. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias J Thampsan

(a) RESIDENCE. No. 519 Franklin Terrace ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth A. Thampsan

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer 011

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Elias Thampsan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. S. Thampsan.
(Address) 519 Franklin Ter.

15 Filed FEB 25 1921 ROBERT P. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1921, to Feb 23, 1921, that I last saw h in alive on Feb 23, 1921, and that death occurred, on the date stated above, at 10-50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carl J Green, M. D.

2-24-1921 (Address) 120½ Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Feb 26 1921
20 UNDERTAKER	ADDRESS
Josiah Sypor	1600 N North Ave

Important. See instructions on back of certificates. If any of these questions are not properly classified. Exact statement of OCCUPATIONS should state

Spec.—5-19-13—M. & T.—500 Bks.

D 51234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51234

CERTIFICATE OF DEATH.

13 X 82

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Reservoir ST.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice O. Adams

(Residence in Baltimore: No. 720 Reservoir St.; — yrs., 2 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, March (Month) 17 (Day), 1877 (Year)

7-AGE, 76 yrs. 11 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Charles Co Md.

PARENTS.

10-NAME OF FATHER, William Brawner

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Sheake

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. B. Freeman

(Address) 720 Reservoir St

15- FEB 25 1921 ROBERT F. BRAUTIGAM

Filed....., 191... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 22 1921, to Feb. 23 1921, that I saw h[er] alive on Feb. 22 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jack. H. Horgan M. D.

2/23, 1921 (Address) 841 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mechanicsville Md

DATE OF BURIAL, Feby 26, 1921

20-UNDERTAKER Chas. E. Black 742 W.

ADDRESS North ave

Spec.—8-24-14—M. & T.—2000 Bks.

Jerome Gorelik

D 5/235

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 5/1235

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. St.; 19 WARD) 1912 REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerome Gorelik

(Residence in Baltimore: No. 877 W. Franklin St.; yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	

6-DATE OF BIRTH, June 25, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 8 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Harry Gorelick

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Jennie Granenberg

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis

(Address) 1811 E Balto St

15- FEB 25 1921 Filed ....., 191.... ROBERT E. CRAUTER Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 25, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 24 1921, to Feb 25 1921, that I saw him alive on Feb 25 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY ..... (Secondary)

~~Uraemia~~ ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Abramson M. D.

Feb 25, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 877 W. Franklin

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 2-28-1921

20-UNDERTAKER Jack Louis — ADDRESS 1811 E Balto St

Remarks

No other infection

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51236 Biezis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51236

CERTIFICATE OF DEATH.

151

3

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 E Pratt St ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Biezis

(a) RESIDENCE. No. 920 E Pratt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 - 1921

7 AGE — Years , Months (7) Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...000...

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Biezis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Antonia Jakeska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Joseph Biezis
(Address) 920 E Pratt St

15 FEB 25 1921 [illegible] Registrar

Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1921, to Feb 24, 1921, that I last saw h— alive on Feb 24, 1921, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Laryngitis (7 mos baby)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ...one...
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr P. Wallenstein, M. D.

, 19 (Address) 6 S Exeter St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 25 1921

20 UNDERTAKER — ADDRESS

John Grebliauckas 425 S. Pac

Sec. 4 of the Act requires that the physician shall state the cause of death in such terms as to properly classified. Exact statement of OCCUPATION should be made. See instructions on back of certificate. Failure to comply with the provisions of this section is punishable by a fine of not more than $100 for each offense. Every undertaker shall keep a record of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Premature Baby

Form 6-9-19—H. P. Co.—1000 Blks.

D51237 HEALTH DEPARTMENT—CITY OF BALTIMORE D51237

CERTIFICATE OF DEATH. X 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Preston Apartments ST.: 11 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Hanway

(a) RESIDENCE. No. Preston Apts. Preston & Guilford Aves WARD. Abingdon Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph B. Hanway

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	83	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Christopher Chapman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robert A. Rouse

(Address) 3417 Springdale Ave

15 FEB 25 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1921, to Feb 24, 1921, that I last saw h[illegible] alive on Feb 23, 1921, and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Arterio Sclerosis

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Tonsilitis & Urimia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Julius Friedenwald, M. D.

Feb 25 1921 (Address) 10 131 St Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon Md.	Feby 26 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St

May be properly classified. Exact statement of OCCUPATION should state ... Very important. See instructions on back of certificates.

D. 51238

HEALTH DEPARTMENT--CITY OF BALTIMORE

D. 51238

CERTIFICATE OF DEATH

1 PLACE OF DEATH — 186 — REGISTERED NO. C .....

CITY OF BALTIMORE (No. Balto City Jail St. 10 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Felix Bell

(Residence in Baltimore: No. ..... St.: ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
M	Col	Single

6-DATE OF BIRTH Unknown, 1 ..... (Month) (Day) (Year)

7-AGE 29 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE (State or country) Unknown

PARENTS

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Records Balto City Jail

(Address) .....

15 Feb 25, 1921

Robert P. Harrison,
Burial Permit Clerk. REGISTRAR

5 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Feb 25, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1921, to Feb 25 1921, that I saw h in alive on Feb 25, 1921, and that death occurred, on the date stated above, at 9 a.m.
The CAUSE OF DEATH* was as follows:

Hanging by neck

(Duration) ..... yrs. 10 mins. ds.

Contributory (SECONDARY) Dislocation Cervical Vertebrae

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. F. Powers M. D.

Feb 25, 1921 (Address) 921 N Chas

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sacred Heart	2-26, 1921
20-UNDERTAKER	ADDRESS
Mathews & Cook	1001 E Balto

IS VERY IMPORTANT. See instructions on back of certificate. It may be prevented unless the blanks are filled EXACTLY. PHYSICIANS should that it may be properly classified. Exact statement of OCCUPATION terms, so

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51239

CERTIFICATE OF DEATH.

6 120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 21 N. Collington Ave ~~St.~~; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles P. Brown

(a) RESIDENCE. No. 21 N. Collington Ave. ~~St.~~; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Jane Brown, deceased

6 DATE OF BIRTH (month, day, and year) April 4, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer. 011

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Brown

11 BIRTHPLACE OF FATHER (city or town) Balto. City
(State or country) Md.

12 MAIDEN NAME OF MOTHER Christianna Kaffman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Parker H. King,
(Address) 21 N. Collington Ave.

15 Filed Feb 25 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1920, to Feb 23, 1921, that I last saw alive on Feb 23, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. L. Mayo Jr. M. D.

2/26 1921 (Address) 1138 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feb. 26 1921
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

Should state exact settlement of OCCUPATION. Be particular. Be sure to state properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51240

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 W Barny ST. 23 WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Baumann

(a) RESIDENCE. No. 6 W Barny ST. 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	white	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 18 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shirt Factory 069

(b) General nature of industry, business, or establishment in which employed (or employer) Mfg Shirts

(c) Name of employer Wm Abrash

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Julius Baumann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Morgan Sabina

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs M. Baumann
(Address) 6 W Barny St

15 Filed Jan 25 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1919, to Jan 24, 1921, that I last saw h alive on Jan 20, 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. R. Campbell M. D.

Jan 24 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	7/26 1921
20 UNDERTAKER	ADDRESS
S. Fow McCarthy	130 E Fort

Important: See instructions on back of certificates. Exact statement of OCCUPATION should state particular kind of work and nature of industry, business or establishment in which employed. Be sure to state whether or not deceased was actually employed at the time of death. Do not use terms "laborer," "housework," "factory," "clerk," "retired," or "unemployed" unless they are properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51241

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51241

CERTIFICATE OF DEATH.

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 E. Cross ST. 24th WARD)

2-FULL NAME Samuel Hyde.

(a) RESIDENCE. No. 136 E. Cross ST., 24th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? 65 yrs. 7 mos. 24 ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Carrie Hyde.

6 DATE OF BIRTH (month, day, and year) July 31, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired .. 031 Machinists
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Hyde.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Tall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carrie Hyde. (Address) 136 E. Cross

15 Filed 3-5-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to February 24, 1921, that I last saw him alive on February 24, 1921, and that death occurred, on the date stated above, at 1.00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 15 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

19 (Address) 1049 Riverside Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	2/28 1921
20 UNDERTAKER	ADDRESS
L. Few McCully	130 E. Fay

Side instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 51242 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 N. Caroline ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Garnetta Kukel.

(a) RESIDENCE. No. 1814 N. Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21 1911

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
9 Years	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt md

PARENTS

10 NAME OF FATHER C. Kukel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt md.

12 MAIDEN NAME OF MOTHER M. Dyott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt md.

14 Informant C. Kukel.
(Address) 1814 N. Caroline st

15 Filed Robert P. Harrison, Registrar
2 5 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1921, to Feb 23, 1921, that I last saw her alive on Feb 23, 1921, and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis. Typhoid & Otitis Media

(duration) Meningitis yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Typhoid & Otitis Media

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Spinal Fluid

(Signed) C. D. Carman, M. D.

2-24 1921 (Address) 1701 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	2/26 1921

20 UNDERTAKER George L. Ruth. ADDRESS 1735 Harford Ave

See instructions on back of certificates. Exact statement of OCCUPATION should state what is very important. Causes of death must be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51243 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51243

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 18V

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Francesa

(a) RESIDENCE. NO. 1021 Ensor St ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 13-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	X	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Carmelo Mancuso

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Josephine Mancuso

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant (Address) J. Hopkins Hosp record

15 Filed Robert P. Harrison, 19 Registrar

25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24-1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 24 1921 to Feb 24 1921

that I last saw her alive on Feb 24 1921

and that death occurred, on the date stated above, at 4 00 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas,
General peritonitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W P Davis, M. D.

19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cem.	2/26 1921
20 UNDERTAKER George J. Ruth	ADDRESS 1736 Hoyal Ave.

Important. See instructions on back of certificates. Exact statement of OCCUPA- should state properly classified.

Spec.—8-24-14—M. & T.—2000 Blks.

D.51244 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51244

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Schroeder ST.; 18 WARD) REGISTERED NO. C 1872

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Roche

(Residence in Baltimore: No. 517 N Schroeder St St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	Single

6-DATE OF BIRTH, March 25th, 1876
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
45 yrs. 6 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edwd. Roche

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Boger

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Hebbitt

(Address) 838 W. Lexington St

15-

Filed 25 1921 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Feb 23 1921, that I saw her alive on Feb. 23 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, Asthma and Chr. Interstitial Nephritis

(Duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis +

(Duration) yrs. mos. 2 ds.

(Signed) J. T. Blanco M. D.

2/24, 1921 (Address) 502 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	2 26, 1921
20-UNDERTAKER H. C. Brauning & Son	ADDRESS 317 N Schroeder St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51245 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51245

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 S Pulaski ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Henkel

(a) RESIDENCE. No. 313 S Pulaski ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? 70 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow Geo Henkel

6 DATE OF BIRTH (month, day, and year) April 17 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Land Abelt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elshner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jos H G Haynes

(Address) 313 S Pulaski St

15 Filed 2 5 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Feb 22, 1921, that I last saw h[illegible] alive on Feb 22, 1921, and that death occurred, on the date stated above, at 8 05 P m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) ... yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Walter A Colt, M. D.

2/24 1921 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Int	Feb 26 1921

20 UNDERTAKER ADDRESS

H. M. Carlson & Bro

May be properly classified. Exact statement of OCCUPATIONS should state very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dr. Humphries 517 South St

D.51246 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51246

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 W Fayette ST.; 19 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie R Jones

(a) RESIDENCE. NO. 1629 W Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jane Jones

6 DATE OF BIRTH (month, day, and year) Dec 7 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm H Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucie Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lucie A Schumann (Address) 1629 W Fayette St

15 FILED 2/5/1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924, to Feb 24, 1924, that I last saw h— alive on Feb 24, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(duration) 4 yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grempler, M. D.

2/25, 1924 (Address) 517 South St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bork Hall Md	Feb 27 1924
20 UNDERTAKER Wm Cook	ADDRESS 502 E Pratt

May be properly classified. Exact statement of OCCUPA-

See instructions on back of certificates.

important.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51247

CERTIFICATE OF DEATH.

10-089

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Booth ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Washington

(Residence in Baltimore: No. 920 Booth St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ~~September~~ 19, 1896
(Month) (Day) (Year)

7-AGE, 24 yrs. 5 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ~~Home~~ (37)

9-BIRTHPLACE, (State or Country), Bonair Va

PARENTS.

10-NAME OF FATHER, Philip Perkins

11-BIRTHPLACE OF FATHER (State or Country) Colville Va

12-MAIDEN NAME OF MOTHER Mattie Taylor

13-BIRTHPLACE OF MOTHER (State or Country), New Kent Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philip Perkins

(Address) 920 N Booth St

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.

3261921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 9 1921, to Febry 22 1921, that I saw her alive on Febry 22 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis and La Grippe

(Duration) ..... yrs. 12 mos. ..... ds.

CONTRIBUTORY (Secondary) Cold & Exposure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R D E Cantrell M. D.

Feb 24, 1921 (Address) 1369 N Carey St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Richmond Va — DATE OF BURIAL, Feb 26, 1921

20-UNDERTAKER Daniel Easton — ADDRESS 916 Pa

D.51248

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51248

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1522 N. Payson St.) (16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Hitchens

(Residence in Baltimore: No. 1817 Summit St. St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1875
(Month) (Day) (Year)

7-AGE, 47 yrs. ..... mos. ..... ds.

If LESS than 1 day ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country) Md

PARENTS.

10-NAME OF FATHER, Ethne Hitchens

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Nancie Jenkson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Burnside

(Address) 1522 N. Payson

15- Filed ....., 191.....
Robert P. Harrison,
Burial Permit Clerk. Registrar.

261921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2/23-, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Geo. C. Elder M. D.
(Coroner.)

2/23 191... (Address) 1436 Riggs

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Salisbury Md.	Feb 26 1921
20-UNDERTAKER Daniel Euston	ADDRESS 416 Park ave

Important. See instructions on back of certificate. Causes should be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51249

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51249

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1775 Montpelier ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Suber

(a) RESIDENCE. No. 1775 Montpelier ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. 7 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catherine Suber

6 DATE OF BIRTH (month, day, and year) July 10 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER John Suber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Catherine Suber
(Address) 1775 Montpelier St

15 Filed ....., 19.....
Robert P. Harrison, Registrar
Burial Permit Clerk

B 36 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25 1921

17 I HEREBY CERTIFY, That I attended deceased from December 31 1920 to February 25 1921, that I last saw him alive on February 24 1921, and that death occurred, on the date stated above, at 6:35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. 2 mos. ds.

Valvular Heart Disease

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted If not at place of death? At Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

21 (Signed) Wallace A. Meyer, M. D.

Feb. 25, 1921 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feb. 28 1921
20 UNDERTAKER	ADDRESS
Henry Storck Son	301 E Eager St.

TION is very important. See instructions on back of ... be properly classified. Exact statement of OCCUPA- ... ch of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51250

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women's Hospital St. 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Brinkman

(Residence in Baltimore: No. Hotel Belmont St.; 7 hrs. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Baby.

6-DATE OF BIRTH, February 25, 1921
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 7 hrs. or 0 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Wm. Arnold Brinkman

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Isabelle Elizabeth McCandlish

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Arnold Brinkman

(Address) Hotel Belmont

15-

Filed....., 1921 Robert P. Harrison, Registrar.

B 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 25, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 24 1921, to Feb. 25 1921, that I saw him alive on Feb. 24 1921, and that death occurred, on the date stated above, at 3 30 a. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Asphyxia neonatorum

..... (Duration) ....yrs....mos....ds.

(Signed) E. H. Duncan M. D.

2.26....., 1921. (Address) Lemuel Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral	Feb. 26 1921
20-UNDERTAKER	ADDRESS
Henry W. Jenkins Sons Co	Orchard & Mt. Vernon Sts

Spec.—8-24-14—M. & T.—2000 Bks.

10.51251

HEALTH DEPARTMENT—CITY OF BALTIMORE

10,51251

CERTIFICATE OF DEATH.

79

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 849 Pierce ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Frisby

(Residence in Baltimore: No. 849 Pierce St. St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH. ....., 1.....
(Month) (Day) (Year)

7-AGE. 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0 0

9-BIRTHPLACE, (State or Country) born in Md
live in the City 18 years

PARENTS.

10-NAME OF FATHER. Father unknown

11-BIRTHPLACE OF FATHER (State or Country). unknown

12-MAIDEN NAME OF MOTHER Fannie Frisby

13-BIRTHPLACE OF MOTHER (State or Country). in Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Frisby

(Address) 213 Bernard St. City

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.

26192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 24, 1921
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Now Feb 10 1920, to Feb 24 1921, that I saw her alive on Feb 23 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows: Mitral Insufficiency

.....

.....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) 1 yrs. ..... mos. 10 ds.

(Signed) T. P. Hughes M. D.

2/25, 1921. (Address) 705 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Dnl-Auburn Cem

DATE OF BURIAL. Feb. 27..., 1921.

20-UNDERTAKER Mrs. R A Elliott

ADDRESS 1725 Ashland Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D.5 1252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.5 1252

X 26

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital Phipps Clinic ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Rebecca Branch

(Residence in Baltimore: No. Johns Hopkins Hospital Phipps Clinic St.; ..... yrs., 5 mos. 13 ds.)

Exact statement of OCCUPATION is very important. Avoid using blank

X

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 13 (Day) 1869 (Year)

7-AGE, 51 yrs. 9 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Florida

PARENTS.

10-NAME OF FATHER, Hiram Cowart

11-BIRTHPLACE OF FATHER (State or Country), Georgia

12-MAIDEN NAME OF MOTHER Barbara Bradshaw

13-BIRTHPLACE OF MOTHER (State or Country), N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. A. Branch

(Address) Daytona Beach Fla.

15- Robert P. Harrison, Fla.

Filed ....., 191.....

2 6 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 24 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept. 11 1920, to Feb. 24th 1921, that I saw her alive on Feb. 23 1921, and that death occurred, on the date stated above, at 10.10 AM

The CAUSE OF DEATH* was as follows:

Acute Nephritis

.....

.....

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Pellagra

..... (Duration) 2 yrs. 0 mos. ..... ds.

(Signed) Ruth E. Fairbank M. D.

Feb. 25, 1921. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 5 mos. 14 ds. In the State ..... yrs. 5 mos. 14 ds.

Where was disease contracted, if not at place of death? Daytona Beach Fla

Former or usual residence " "

19-PLACE OF BURIAL OR REMOVAL, Daytona Beach Fla. DATE OF BURIAL, 1926 ....., 1921

20-UNDERTAKER Philip Herring ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51253 HEALTH DEPARTMENT—CITY OF BALTIMORE D/51253

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Young.

(a) RESIDENCE. No. Poplar Valley Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 22 Feb. 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) Coal

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Young.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sister Florence, (Address) Poplar Valley

15 Filed 19 Robert P. Harrison, Registrar

B26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from No record 19 to 19, that I last saw him alive on July 23 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Val. Disease of Heart

Influenza (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. Alderson, M. D.

Feb 28 1921 (Address) 1133 Valley Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ballo Cemetery	Feb 28 1921

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Guilford Ave

Filed ... See instructions on back of certificates. Exact statement of OCCUPATION ... should state ... be properly classified. ... very important. ... may ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51254 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51254

115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat St.: 28 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Eline

(a) RESIDENCE. No. Baltimore Md St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ×

6 DATE OF BIRTH (month, day, and year) Feb 9th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Emmitsburg Md-

PARENTS

10 NAME OF FATHER Sam. P. Eline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Pa-

12 MAIDEN NAME OF MOTHER Catharine Adams

13 BIRTHPLACE OF MOTHER (city or town) Adams Co (State or country) Penna

14 Informant Records of Mt Hope Retreat (Address) Mount Hope Retreat

15 Filed 61921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th 1894, to Feb 25th 1921, that I last saw h[er] alive on Feb 24th 1921, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Hepatitis (Complicated by Syphilis -

abt (duration) 0 yrs. 0 mos. 21 ds.

CONTRIBUTORY (Secondary) Chr. Melancholia -

One (duration) 27 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Feb 25. 1921 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmitsburg Md	Feb 28 1921

20 UNDERTAKER H. C. Winfield ADDRESS 914 Greenmt

See instructions on back of certificate. Exact statement of OCCUPATION should state whether employer or employee, and if employer, whether actively engaged in business or not, so that the cause of death may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51255 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51255

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Maryland Ave ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Golden

(a) RESIDENCE. No. 4 Md Ave W Lafayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 16th 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER James H. Golden

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Eugenia Fuchs

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant James H. Golden
(Address) 4 Md Ave Wayside

15 Filed Robert P. Harrison, Registrar
6102 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1921, to Feb. 24, 1921, that I last saw him alive on Feb 24, 1921, and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. C. Kelly, M. D.

, 19 (Address) 335 E 31st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	2/26/ 19 21
20 UNDERTAKER John F. Howard & Son	ADDRESS Govt Ave

Instructions on back of certificates. Exact statement of OCCUPA- ... state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other infection prior

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51256 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51256

CERTIFICATE OF DEATH.

REGISTERED NO. 781

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Martin

(a) RESIDENCE. No. ..... ST., ... WARD. Pocomoke City, Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hattie S. Martin

6 DATE OF BIRTH (month, day, and year) [illegible] 1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm. Martin

11 BIRTHPLACE OF FATHER (city or town) [illegible] (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Clark

13 BIRTHPLACE OF MOTHER (city or town) [illegible] (State or country) Md.

14 Informant P. J. Sweeney
(Address) Warden Md. Penitentiary

15 Filed 19 Robert P. Rayburn, Registrar
6 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from November- 9, 1920, to February- 24, 1921, that I last saw him alive on February- 23, 1921, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Leucemia - Ex Exanition - Cardiac Failure
(Pulmonary T.B.?)

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia
(duration) yrs. 3 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William F. Schwartz, M. D.

Feb. 24, 19 21 (Address) Md. Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pocomoke City Md. DATE OF BURIAL Feb 26 19 21

20 UNDERTAKER Samuel A. Huxley ADDRESS Pocomoke City Md.

Be sure to fill in all items. Use terms which are properly classified. Exact statement of OCCUPATION and state CAUSE OF DEATH. See instructions on back of certificates.

D.51257 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mt Gull Hospital REGISTERED NO. C 108

CITY OF BALTIMORE (No. 26 St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian E. Delevan

(Residence in Baltimore: No. Belleview Ave. Belair Road St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, April (Month) 6 (Day), 1891 (Year)

7-AGE, 29 yrs. 10 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Joseph Dailey

11-BIRTHPLACE OF FATHER (State or Country), Norway

12-MAIDEN NAME OF MOTHER Minnie Radloff

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Morland Sister

(Address) 65 Belleview Ave. Ridgely

15-

Filed ....., 19.... Robert P. Harrison Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) / 24 (Day) / 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: over

Exhaustion

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. E. Slade (Coroner), M. D.

191 (Address) 1737 Bray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Feb 25, 1921

20-UNDERTAKER H. E. Hughes

ADDRESS 424 N. Broadway

PHYSICIANS should state exact statement of OCCUPATION is very properly classified.

Instructions on back of certificate.

D.51258

HEALTH DEPARTMENT---CITY OF BALTIMORE

D.51258

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 26 N Rose Lane ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Kilroy

(Residence in Baltimore: No. 2621 Maryland Avenue St.; 55 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX M

4-COLOR OR RACE W

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widower

6-DATE OF BIRTH December (Month) 31 (Day) 1845 (Year)

7-AGE 75 yrs. 1 mos. 23 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Gardner
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE (State or country) Ireland

PARENTS

10-NAME OF FATHER Hugh Kilroy

11-BIRTHPLACE OF FATHER (State or country) Ireland

12-MAIDEN NAME OF MOTHER Catherine McDermott

13-BIRTHPLACE OF MOTHER (State or country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Mary G. Kilroy

(Address) 2621 Maryland Avenue

15- Filed ..... 191.....

Robert P Harrison,
REGISTRAR
Burial Permit Clerk.

R 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 7/27 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7/17, 1921, to 7/25 1921, that I saw h.. alive on 7/27 1921, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH*, was as follows:

Myocardial Degeneration

Arterio Sclerosis

(Duration) 5 yrs. mos. ds.

Contributory (SECONDARY) Cerebral Anaemia

(Duration) yrs. 5 mos. 10 ds.

(Signed) Wm F. Cassedy M. D.

7/28 1921 [Address] Roland Pk.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 7/29, 1921

20-UNDERTAKER Henry W. Mears & Son

ADDRESS 105 N. Calvert

Fill in all blanks if you can. It may be necessary to make inquiries of persons other than those present at death. Information is very important. See instructions on back of certificate. Exact statement of OCCUPATIONS should be made as it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51259

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51259

CERTIFICATE OF DEATH.

79-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 Whitelock St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hiram K. Herman

(a) RESIDENCE. No. 900 Whitelock St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Herman

6 DATE OF BIRTH (month, day, and year) Aug 18th 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ~~Balto Md~~

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jonas Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Katz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Sarah Herman

(Address) 900 Whitelock

15 Filed Robert L. Harrison Registrar

2 6 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 20. 1910, to Feby 24. 1921, that I last saw him alive on Feby 24. 1921, and that death occurred, on the date stated above, at 11 50 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Streptococcus viridans);

Aortic stenosis & insufficiency (11 years)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) Louis P. Hamburger, M. D.

Feb 26, 1921 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	Feb 27th 1921
20 UNDERTAKER	ADDRESS
David Sondheim	118 W Lexington St

Instructions on back of certificates. Exact statement of OCCUPA- should state

D. 51260 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51260

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3137 Elliott ST.; 1 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gregor Romanuck.

(Residence in Baltimore: No. 3137 Elliott St.; yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 2 9 yrs. mos. ds. If LESS than 1 day, not known hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 046

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Max Romanuck

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Katrina Katanni

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Romanuck

(Address) 3137 Elliott St

15-

Filed ....., 191.....

Robert F. Harrison, Registrar.

86192 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nibula Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thomas Ryan M. D.
(Coroner.)

Feb 26, 1921 (Address) 806 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Feb 27, 1921
20-UNDERTAKER	**ADDRESS**
John Grblinuckas	425 S Paca St

Instructions on back of certificate. Exact statement of OCCUPATION is very important. PHYSICIANS should state the property classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.51261 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 10.51261

CERTIFICATE OF DEATH.

REGISTERED No. 282

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 Portland ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Rogoche

(a) RESIDENCE. No. 630 Portland ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret Rogoche

6 DATE OF BIRTH (month, day, and year) Feb. 5 - 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	-	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Benedict Rogoche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Daujanciute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Margaret Rogoche
(Address) 630 Portland St.

15 Filed . 19 Robert P. Harrison
Registrar

2261921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1921, to Feb. 25, 1921, that I last saw him alive on Feb. 25, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) none determined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) John A. Buchness, M. D.

. 19 (Address) 650 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 28. 1921

20 UNDERTAKER John Grebliauckas ADDRESS 425 S. Pace St.

Instructions on back of certificates. Exact statement of OCCUPATION required. Should state whether primary classified.

D. 51262 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51262

CERTIFICATE OF DEATH.

1200

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1418 E Layfatte av ST. 9 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Gutbrod Lach.

(Residence in Baltimore: No. 1418 E. Layfatte av ST. 50 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, January 19th, 1850
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
71 yrs. 1 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, John Gutbrodlach.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Kuckuck

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Frank J. Brinn

(Address) 1418 E Layfatte av

15- Robert P Harrison

Filed....., 191..... Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

2-26, 192[illegible] (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Carmel Cemty	2-26, 1921
20-UNDERTAKER	ADDRESS
Geo. J. Ruth	735 Hanford av

Exact statement of OCCUPATION is very

plain ...ctions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51263 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51263

CERTIFICATE OF DEATH. 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3100 E Lombard St.: 1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian E Weber

(a) RESIDENCE. No. 3100 E Lombard St., 1 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) " 000

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo Weber deceased

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Cath Killeen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant August Weber

(Address) Rockdale Parkeban

15 Filed 19 Robert P. Harrison, Registrar

B 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2.25 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1920, to Febry 25, 1921, that I last saw h.. alive on Febry 25, 1921, and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows: Acute Nephritis over

1 (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Congestion of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinic

(Signed) Hugh Morse M. D.

. 19 (Address) Gardenville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Tem	Feb 28 1921
20 UNDERTAKER	ADDRESS
Wm. Cook.	502 E. North ave

THIS IS very important. DO not detach.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gave history of having had Typhoid Fever one yrea ago.

No other abnormal condition.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51264 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51264

CERTIFICATE OF DEATH.

9-091

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cressley Hughes.

(a) RESIDENCE. NO. 3131 Leeds Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 11 mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Presley Hughes

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D C

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Presley Hughes
(Address) 3131 Leeds Av

15 Filed Robert P. Harrison, Registrar
2 6 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1921, to Feb. 26, 1921, that I last saw him alive on Feb 25, 1921, and that death occurred, on the date stated above, at 5:40 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Positive culture.

(Signed) B Macgowan, M. D.

2/26/21 (Address) Sydenham Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Feb. 26 1921
20 UNDERTAKER C. W. Dill	ADDRESS 319 Fredk Ave

THIS is very important. See instructions on

Spec. 6-9-19—H. P. Co.—1000 Blks.

51265 HEALTH DEPARTMENT—CITY OF BALTIMORE 51265

CERTIFICATE OF DEATH.

REGISTERED NO. 1702

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1112 Fort. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. F. Link

(a) RESIDENCE. NO. 1112 Fort ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mary E. Link.

6 DATE OF BIRTH (month, day, and year) Aug. 12 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6	12	

8 OCCUPATION OF DECEASED 061

(a) Trade, profession or particular kind of work Policeman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos. H. Link

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Lidia Emmitt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary E. Link.

(Address) 1112 Fort Ave

15 FEB 27 1921 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1921, to Feb. 24, 1921, that I last saw him alive on Feb. 24, 1921, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 12 hrs. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm. T. Seabury, M. D.

2/24. 1921 (Address) 638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greden Hill Cemetery	Feb. 28 1921
20 UNDERTAKER	ADDRESS
E. J. Fanning	1466 Gilday Ave

TION is very important. See instructions on back

D51266 HEALTH DEPARTMENT—CITY OF BALTIMORE D51266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH, CITY OF BALTIMORE (No.) 2319 McCulloh St.; 13 WARD) REGISTERED No. C 1921

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny Rubinow

(Residence in Baltimore: No. 2319 McCulloh St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1860 (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, House-wife
(b) General nature of industry, business, or establishment in which employed (or employer), 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Baltimore St

15- Filed FEB 27 1921 ROBERT E KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2/24, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. mos. ds.

(Signed) C. E. Wade M. D.
(Coroner)
2/25/21 (Address) 1437 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rehrersouthern ave | DATE OF BURIAL, 2/27/21

20-UNDERTAKER Jack Lewis | ADDRESS 1411 E Baltimore

Important. See instructions on back of Certificate.

Rec'd 6-9-19—H. P. Co.—1000 Bks.

D51267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51267

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 Thames ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Manuel Ameada

(a) RESIDENCE. No. 1632 Thames ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 900

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Ameada

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Theresa Ameada

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant Joseph Ameada (Address) 1632 Thames St

15 Filed FEB 27 1921 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1921, to Feb. 26, 1921, that I last saw him alive on Feb. 26 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bronchs-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Jose Gutierrez, M. D.

, 19 (Address) 2357 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem. DATE OF BURIAL Feb. 28 1921

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Pach

TION is very important. See instructions on back of

Zoll.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51268

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 351 Whitridge Ave ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C Zoll

(a) RESIDENCE. No. 351 Whitridge Ave ST., ... WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ardine J & Emma E Zoll

6 DATE OF BIRTH (month, day, and year) March 15 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Living 086

(b) General nature of industry, business, or establishment in which employed (or employer): Business

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Hagerstown Md

PARENTS

10 NAME OF FATHER: Jacob Zoll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sam'l C Zoll
(Address): 351 Whitridge Ave

15 Filed FEB 27 1921 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby. 22 1921 to Feby. 25 1921
that I last saw him alive on Feby. 25th 1921
and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. G. Tillsbury, M. D.

. 19 (Address) 602 E. 29th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 28 1921
20 UNDERTAKER	ADDRESS
Wm Reed	502 E Fait Ave

THIS IS VERY Important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51269

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 19 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sr. Mary Immaculata

(a) RESIDENCE. No. Good Shepherd Convent St.: Mosher & Holliday Ward:

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sisters of Good Shepherd
(Address) Mt. & Hollins St.

15 Filed FEB 27 1921 [redacted] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26 1921

17

I HEREBY CERTIFY, That I attended deceased from 10/20, 1921, to 2/26, 1921, that I last saw h[illegible] alive on 10/26, 1921, and that death occurred, on the date stated above, at 4.40 p. m.

The CAUSE OF DEATH* was as follows:

Fracture left Femur Cause

(duration) yrs. 4 mos. 10 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. A. Reed, M. D

2/26 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Private Lot Good Shepherd

DATE OF BURIAL 2/28 1921

20 UNDERTAKER John F. Dalrymple

ADDRESS 318 Eutaw

TION is very important. See instructions on back of

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

The fracture was the result of a fall in the Chapel at Convent of Good Shepherd.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51270 HEALTH DEPARTMENT—CITY OF BALTIMORE D51270

CERTIFICATE OF DEATH. X 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Carey

(a) RESIDENCE. No. Laurel Md ST., WARD. Laurel Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Est Tracy

(Address) Laurel Md

15 Filed FEB 27 1921 ROBERT J. REUTER Registrar Vital Statistics Board

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1921, to Feb. 26, 1921, that I last saw h[e] alive on Feb. 26, 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Suppurative appendicitis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Myocarditis Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of Feb 22 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. McElwain, M. D.

, 19 (Address) 1 Doughs Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Howard Co	2/28 1921
20 UNDERTAKER	ADDRESS
Wm J Tokephes	131 E Pratt

TION is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51271

CERTIFICATE OF DEATH.

10-091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 Pierce ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Banks.

(a) RESIDENCE. No. 932 Pierce ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Samuel Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington

12 MAIDEN NAME OF MOTHER Mary E. Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mary E. Wallace (Address) Washington D.C.

15 Filed FEB 27 1921, 19 ROBERT J. BRUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1921, to Feb 25, 1921, that I last saw h— alive on Feb 25, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical - Rusty Sputum

(Signed) Willem H. Hughes, M. D.

Feb 25, 1921 (Address) 1209 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D-C-	2/27/21, 19
20 UNDERTAKER	ADDRESS
Samuel M. Chase-son	1400. Mosher st

TION IS VERY IMPORTANT. SEE INSTRUCTIONS ON REVERSE SIDE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51272 HEALTH DEPARTMENT—CITY OF BALTIMORE D51272

CERTIFICATE OF DEATH. 79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 N. Schroeder ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E Hattaue

(a) RESIDENCE. NO. 313 N. Schroeder ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Hattaue

6 DATE OF BIRTH (month, day, and year) Jan 22 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45	45	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Francis Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltic

14 Informant John E. Hattaue (Address) 313 N. Schroeder st

15 Filed FEB 27 1921 19 ROBERT J. BRAGER Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 22, 1921, to Feby 24, 1921, that I last saw her alive on Feby 24, 1921, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Valvular cardiac disease
Mitral & aortic
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Objective

(Signed) Emmeline Thomas M. D.

, 19 (Address) 330 N Charles st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 3/1/21 19

20 UNDERTAKER Samuel W. Chrisson — ADDRESS 1400 Mosher st

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

51273 HEALTH DEPARTMENT—CITY OF BALTIMORE D51273

CERTIFICATE OF DEATH.

18 REGISTERED NO.....

1-PLACE OF DEATH

(a) CITY OF BALTIMORE (NO. 1 Sabine Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G Walker

(a) RESIDENCE. NO. 1 Sabine Ave ST. Mt. Washington WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Walker

6 DATE OF BIRTH (month, day, and year) July 4, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Japaner 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bartlett & Hayward Balto

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Daniel F. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Georgeanna Freel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Mrs Howard L Burns

(Address) 1327 W. Lanvale St

15 FEB 27 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 7th, 1921, to Feb 25th, 1921, that I last saw h~~im~~ alive on Feb 25 1921, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Carbuncle (duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Erysipelas (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ? Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Leonard E Keach M. D.

2/27, 1921 (Address) 2231 St Paul St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Feb 28 1921

20 UNDERTAKER Wm J Tickner & Sons ADDRESS North & Pa

FROM IS VERY important

Spec. 6-9-19—H. P. Co.—1000 Blks.

Lillie B Anderson

D51274

D51274

92

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 532 McMechen ST.; 14 WARD)

2-FULL NAME Lillie Bell Anderson

(a) RESIDENCE. NO. 532 McMechen ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Fe	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry W Anderson

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Lillie Olmer

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Harry W. Anderson
(Address) 532 McMechen

15 Filed FEB 27 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1921, to Feb 25, 1921, that I last saw h[illegible] alive on Feb 25, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia,

Indefinite
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) Dr. Garland Chrisfield, M. D.

(Address) 1534 E. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Feb 27th 1921

20 UNDERTAKER Clarence E Umpleby ADDRESS 1264 Carey

TION IS very important. [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51275 HEALTH DEPARTMENT—CITY OF BALTIMORE D51275

CERTIFICATE OF DEATH. 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Ething ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Washington Moore

(a) RESIDENCE. NO. 1909 Ething ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 28-1904

7 AGE 16 Years 10 Months 24 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lulu Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lulu Harbaugh (Address) 1909 E Ething

15 Filed FEB 27 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Feb 24, 1921, that I last saw h Ex alive on Feb 23, 1921, and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

2/25 1921 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn Cem Ptd Feb 28 1921

20 UNDERTAKER ADDRESS

George H. Holland 1631 Druid Hill Ave

Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

051276 HEALTH DEPARTMENT—CITY OF BALTIMORE 42 051276

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4723 Locust Ave (Govans) ST.; 27 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel O. Gordy

(Residence in Baltimore: No. 4723 Locust Ave St.; 1 yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec (Month) 23 (Day) 1891 (Year)

7-AGE, 29 yrs. 2 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer): 186

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Alex W. Garden

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Alberta E. Knowles

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander W. Garden

(Address) RFD 6 28th St

15- ROBERT F KRAUTER

FEB 27 1921 191... Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 26 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 16th 1921, to Feb 26 1921, that I saw her alive on Feb 26 1921, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovary & Tube

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Phillips M. D.

191... (Address) 2350 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Jarrettsville Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Hebron Inc	Feb 28th, 1921
20-UNDERTAKER	ADDRESS
E. Schloman & Son	Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51277 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51277

CERTIFICATE OF DEATH. 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2452 Buchanan St 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hicks

(a) RESIDENCE. No 2452 Buchanan St WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Richard Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Violet Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mattie Mack
(Address) 2444 Oak St

15 FILED FEB 27 1921 ROBERT F. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1921, to Feb 24, 1921, that I last saw h[illegible] alive on Feb 24th, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis and General peritonitis

(duration) x yrs. x mos. 6 ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) x yrs. x mos. 6 ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Geo. Hall, M. D.

, 19 (Address) 1826 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	Feb 27 1921
20 UNDERTAKER Mrs Robt a Elliott	ADDRESS 1725 Division Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51278

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51278

40

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 E Federal ST.: 8 WARD)

2-FULL NAME Alice E. Sanderson

(a) RESIDENCE. No. 1632 E Federal ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13th 1855

7 AGE: Years 66 | Months 1 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry W Burley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary J Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Daisy M Eagle

(Address) 1662 E Federal St

15 Filed FEB 27 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1920, to Feb 26, 1921, that I last saw h alive on Feb 25, 1921, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 3 mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Sanderson M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Mar 14 1921

20 UNDERTAKER: Robt L Turner Inc — ADDRESS 1942 N Broadway

TION is very important. See Instructions on Back of Certificate

Spec.—8-24-14—M. & T.—2000 Bks.

D51279 HEALTH DEPARTMENT—CITY OF BALTIMORE D51279

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE: (No. Eppler Ave & Chestnut Hill Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene J. Stauer

(Residence in Baltimore: No. Eppler Ave & Chestnut Hill Ave St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 8 (Month) (Day), 1916 (Year)

7-AGE, 4 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edward M. Stauer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward M. Stauer

(Address) 5416 Eppler Ave Parkville

15- FEB 27 1921 ROBERT J. KRAUTER Registrar.

Filed....., 191....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 25 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 25 1921, to Feb 25 1921, that I saw him alive on Feb 25 1921, and that death occurred, on the date stated above, at 5:40 p.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. ds.

(Signed) Dr. Edw. H. Benson M. D.

Feb 25, 1921 (Address) Dundalk, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, Mar 1, 1921

20-UNDERTAKER Robt J. Turner Inc — ADDRESS 1442 W Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51280 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D51280

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., 1 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Gabler

(a) RESIDENCE. No. 4128 Collington Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1½ yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hospital Reports

(Address)

15 Filed FEB 27 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1921

17

I HEREBY CERTIFY, That I attended deceased from May 22, 1920, to Feb 24, 1921, that I last saw her alive on Feb 24, 1921, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) G. C. Medairy, M. D.

19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Feb. 28 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler.	403 S. Wolfe

THIS IS VERY IMPORTANT

Form —6-9-1°—H. P. Co.—1000 Bks.

D51281 ✓ 1202 D51281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. McNamara

(a) RESIDENCE. No. 3408 Dillon St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Walter McNamara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Brogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records,
(Address) New City Hospital

15 Filed FEB 27 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 19 21

17

I HEREBY CERTIFY, That I attended deceased from January 5, 19 21. to February 25 19 21.

that I last saw h... alive on February 24, 19 21.

and that death occurred, on the date stated above, at 5:35 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Hemorrhage

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical test

(Signed) B. B. Seaman, M. D.

2/25/21 Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	March 1 1921
20 UNDERTAKER Lilly and Zeiler.	ADDRESS 403 S. Wolfe

TION is very important. Be accurate

Anna Beatty

Rev.—6-9-19—H. P. Co.—1000 Blks. D51282

HEALTH DEPARTMENT—CITY OF BALTIMORE D51282

CERTIFICATE OF DEATH.

103

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2505 Gilmore ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Beatty

(a) RESIDENCE. NO. 2505 Gilmore ST.. 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Beatty

6 DATE OF BIRTH (month, day, and year) March 23, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 137

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER — Cullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Joseph Beatty (Husband) 2505 E. Gilmore Ave

15 Filed 19 FEB 27 1921 WILLIAM H. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 22 . 19 21 . to Feb 25 . 19 21 .

that I last saw h a alive on Feb 25 . 19 21 .

and that death occurred, on the date stated above, at 1 . m.

The CAUSE OF DEATH* was as follows:

Cardiac gastro intents

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. Wanton, M. D.

Feb 27, 1921 (Address) 412 Bentley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	March 1 1921
20 UNDERTAKER Lilly & Zeiler.	ADDRESS 403 S. Mosher

ATION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51283 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51283

80

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 S. Ebenezer ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Bishop

(a) RESIDENCE. No. 323 S. Ebenezer ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. Bishop

6 DATE OF BIRTH (month, day, and year) June 15th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Varnisher 051

(b) General nature of industry, business, or establishment in which employed (or employer) Southern Enamel Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George A. Bishop.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Michael

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E. Bishop (Wife)
(Address) 323 S. Ebenezer St.

15 Filed FEB 24 1921 19 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 19 21, to Feb 23 19 21, that I last saw h[illegible] alive on Feb 20 19 21, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2/24, 19 21 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Feb 28 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D51284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51284

CERTIFICATE OF DEATH.

REGISTERED No. C 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 N. Vincent ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Madden

(Residence in Baltimore: No. 1018 N. Vincent St ST.; 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June 10, 1887 (Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Milburn

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susanna Milburn

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosie Travis

(Address) 1018 N. Vincent St

15- FEB 27 1921 BOARD OF HEALTH

Filed ....., 191... Burial Permit Clerk. Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 23, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 5 1921, to Feb. 20 1921, that I saw her alive on Feb. 20 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Acute Articular Rheumatism

(Duration) yrs. mos. 40 ds.

(Signed) J. M. Hayes M. D.

Feb. 26, 1921 (Address) 1513 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	2-27, 191...
20-UNDERTAKER	ADDRESS
Wm Groshon	1217 Pine

William H. Blizzard

D 51285 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51285

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2711 E. North Ave ST.: 15 WARD)

REGISTERED No. C 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Blizzard

(Residence in Baltimore: No. 2711 E. North Ave St.: (yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1857 (Year)

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country) Hanover Fed. Md.

PARENTS.

10-NAME OF FATHER, Caleb M Blizzard

11-BIRTHPLACE OF FATHER (State or Country) Hanstead Md.

12-MAIDEN NAME OF MOTHER Mary Kinsley

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlotte Blizzard

(Address) 2711 W North Ave

15- FEB 27 1921

Filed ..... 191.... ROBT. J. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) H. C. Wade M. D.
(Coroner.)

2737 E. North Ave (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn.	Feb 28, 1921
20-UNDERTAKER	ADDRESS
M Fahey & Sons.	1807 N Worth Ave

Important. See instructions on back of certificate.

D51286 HEALTH DEPARTMENT—CITY OF BALTIMORE D51286

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2612 Wilkens ave ST.: 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Weinstein Hahn

(Residence in Baltimore: No. 2245 Wilkens ave St.; (yrs., 75 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, ... Aug (Month) 18 (Day), 1843 (Year)

7-AGE, 77 yrs. 6 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John K. Müller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna E. Eilbacher

(Address) 2246 Wilkens ave

15 FEB 27 1921 Filed....., 191.... Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (Duration) suddenly yrs. mos. ds.

(Signed) James M. Benton M. D. (Coroner.)

Feb 26 1921 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cemetery	Feb 28, 1921
20-UNDERTAKER	ADDRESS
T. A. Kraus & Son	763 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 51287

102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2432 Woodland Ave 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J Soff

(a) RESIDENCE. No. 2432 Woodland ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Wm C Soff

6 DATE OF BIRTH (month, day, and year) June 8 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John H Boone

11 BIRTHPLACE OF FATHER (city or town) U S of Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Schilling

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Walter H Soff
(Address) 2432 Woodlawn Ave

15 Filed . 19 ROBERT E LEACH Registrar

FEB 26 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1921, to Feb 27, 1924, that I last saw her alive on Feb 26 1924 and that death occurred, on the date stated above, at 12 40 p. m.

The CAUSE OF DEATH* was as follows:

Ulceration of Stomach with perforation

several years
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. H. Beckley, M. D.

, 19 (Address) 126 W. Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Lawn & Mausoleum	1924

20 UNDERTAKER ADDRESS

Wm Cook 532 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51288 — 55-001 — D51288

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 Barnes ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mc Gowan Barnes

(a) RESIDENCE. NO. 1702 ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J. McGowan

6 DATE OF BIRTH (month, day, and year) Nov 3 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia

14 Informant George J. McGowan

(Address) 1702 W Barnes St

15 Filed FEB 28 1921 ROBERT F. [illegible] Registrar

Burial Permit Otort

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 19...., to....., 19....,

that I last saw h.... alive on....., 19....,

and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

Sleeping Sickness

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

....., 19.... (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	3/1 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E Fort Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51289

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1837 E. Eager ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Leo Bertrand

(a) RESIDENCE. NO. 1837 E. Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 8 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Arthur Leo Bertrand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Minnie Sadie Bobel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Arthur Leo Bertrand

(Address) 1837 E. Eager

15 Filed FEB 28 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1921 to Feb 27, 1921

that I last saw h. living alive on Feb 27, 1921

and that death occurred, on the date stated above, at 4 00 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Indianapolis

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Fred W. Reynolds, M. D.

2-27-21 (Address) 800 N. Nathan Dike

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 3/1 1921

20 UNDERTAKER Williams Coop

ADDRESS 1502 E. 10th

D51290 HEALTH DEPARTMENT--CITY OF BALTIMORE D51290

CERTIFICATE OF DEATH

REGISTERED No. C 79

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Belvedere Ave Westport ST. 25 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah G. Perryman

(Residence in Baltimore: No. Belvedere Ave Westport St.: 1 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH August 29, 1836 (Month) (Day) (Year)

7 AGE 84 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Lady
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Perryman Md.

PARENTS

10 NAME OF FATHER George Perryman

11 BIRTHPLACE OF FATHER (State or country) Perryman Md

12 MAIDEN NAME OF MOTHER Isabella Gover

13 BIRTHPLACE OF MOTHER (State or country) Perryman Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Warren Crampton

(Address) 1319 Park Ave.

FEB 28 1921

Filed . 191

BOARD OF HEALTH

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feby 27, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1921, to Feby 27 1921, that I saw her alive on Feby 26, 1921, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 1 mos. ds

Contributory (SECONDARY) Cerebral embolism

(Duration) yrs. mos. 14 ds.

(Signed) Geo S McKeehan M. D.

Feby 27, 1921 (Address) Morrell Park Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Perryman Md

19 PLACE OF BURIAL OR REMOVAL Spesutia Cem Harford Co. DATE OF BURIAL 3-1 1921

20 UNDERTAKER Thomas Kenkins Sons Co ADDRESS 1411 Hillsdale & Orchard Sts

State CAUSE OF DEATH in plain words. Do not use abbreviations or initials. Name of disease alone is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51291

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 N. Calvert ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Morris Howard.

(a) RESIDENCE. No. 1016 N. Calvert ST., 11 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Riley Howard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Waters

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant John D Howard
(Address) 209 W. Monument St

15 FEB 28 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1921, to Feb. 26, 1921, that I last saw h.... alive on Feb. 26, 1921, and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Left Lower Lobe)

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? 1016 N. Calvert St

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Physical Examination

(Signed) [illegible] Levin, M. D.

1924 (Address) The Walbert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb 27 1921
20 UNDERTAKER Henry A Jenkins & Sons Co	ADDRESS Orchard & McCulloh

IF NOT BURIED IN CITY, GIVE TOWN AND COUNTY

MAY 7 1921

Dr Town - Wilson

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51292 HEALTH DEPARTMENT—CITY OF BALTIMORE D51292

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 446 N. Robinson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Virginia Schuchman

(a) RESIDENCE. NO. 446 N Robinson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Oct 13, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer No

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Raymond Schuchman

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Elmabell Coyne

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Raymond Schuchman (Address) 446 N Robinson

15 Filed FEB 28 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 27th, 1921, to Feb 26th, 1921, that I last saw her alive on Feb 25th, 1921, and that death occurred, on the date stated above, at 10:10 A. m.

The CAUSE OF DEATH* was as follows:

Unresolved Lobar Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical Signs

(Signed) Leonard McParker, M. D.

(Address) 1114 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 28 1921

20 UNDERTAKER ADDRESS

Edmund W. Coughlin 924 E Eager St

TION is very important. See instructions on back

Spec.—5-19-13—M. & T.—500 Bks.

D 51293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 116 Dorchester Ave Lafayette REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia B. Hall

(Residence in Baltimore: No. Life 116 Dorchester Ave Life St. ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, ... 1 (Month) ..... 6 (Day), 1845 (Year)

7-AGE, 76 yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, Richard Younger

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Cecelia Wonn

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert V. Hall

(Address) 116 Dorchester Ave

15-

Filed FEB 28 1921, 191.....

ROBERT J. KRAUSE
Dental Examiner

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 26 (Month) (Day), 1921 (Year)

17- I HEREBY ~~CERTIFY~~, That I attended deceased from Feb 9 1921, to Feb 26 1921, that I saw her alive on Feb. 26 1921, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Heart Disease

Disease was Chronic, Do not Know exact duration (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. T. Norris M. D.

....., 191... (Address) 10 West 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, W Lo Lawn Cemetery

DATE OF BURIAL, Mar 1 1921

20-UNDERTAKER Bertram L Gore

ADDRESS 1725 W. Lafayette Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51294

CERTIFICATE OF DEATH.

REGISTERED NO. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Rockdale Ave. ST. Rosedale WARD)

2-FULL NAME Joshua T. Gallagher

(a) RESIDENCE. NO. 12 Rockdale Ave. ST. WARD. Rosedale

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie I. Gallagher

6 DATE OF BIRTH (month, day, and year) June 14th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Quarry

(c) Name of employer Wm Lobley & Co. Frederick

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Gallagher

11 BIRTHPLACE OF FATHER (city or town) Preston (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Mary Steeger

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Mrs Maggie I. Gallagher (Address) 12 Rockdale Ave. Roseheights

15 Filed FEB 26 1921 ROBERT P. [illegible] Registrar

Serial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1911, to Feb 25, 1921, that I last saw h— alive on Feb 25, 1921, and that death occurred, on the date stated above, at 5:40 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? York Pa.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical sign

(Signed) Edwin H. Benson, M. D.

Febr. 192[illegible] (Address) Overlea, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL March 1st 1921

20 UNDERTAKER Fredk Lassahn Son

ADDRESS Fulkerton Md

CAUSE OF DEATH must be entered by physician in plain terms. Indefinite answers such as "Heart Failure," "Old Age," "Paralysis," "Convulsions," "Cancer," "Consumption," without stating the primary cause of the fatal disease, are insufficient. See instructions on back of certificates. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51295 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D 51295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Volunteers of America Hospital — REGISTERED NO. 92

CITY OF BALTIMORE: (No. 418 W. Lexington ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schultheis

(a) RESIDENCE. No. Main St. Lakeland, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Schultheis

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER Schepfers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry John Schultheis (Son) (Address) Lakeland Md.

15 Filed FEB 26 1921, 19 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23 —, 1921, to Feb. 25, 1921, that I last saw her alive on Feb. 25, 1921, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Double, basal, Lobar Pneumonia

(?) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(?) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) J. L. Payaweller, M. D.

, 19 (Address) 418 W. Lexington St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 28 1921
20 UNDERTAKER	ADDRESS
Harry H. Nitzke	1531 N. Fremont Ave

CAUSE OF DEATH. See instructions on back of certificates. ATTENTION is very important.

Form.—6-9-19—H. P. Co.—1000 Bks.

D51296 HEALTH DEPARTMENT—CITY OF BALTIMORE D51296

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 W. Fort Ave. ST.: 23 WARD) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas K. Eunick

(a) RESIDENCE. NO. 106 W. Fort Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ellen Eunick

6 DATE OF BIRTH (month, day, and year) May 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired(Machinist)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Cora B. Clark

(Address) 106 W. Fort Ave.

15 Filed FEB 28 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25" 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921 to Feb. 25 1921, that I last saw h. im alive on Feb 24 1921, and that death occurred, on the date stated above, at 11.05 A.m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Bright's disease

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hawkins, M. D.

2/26 1921 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 28 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N. Calvert St

D51297 HEALTH DEPARTMENT—CITY OF BALTIMORE D51297

CERTIFICATE OF DEATH.

REGISTERED No. C 159

1-PLACE OF DEATH Cathedral & Richmond Streets

CITY OF BALTIMORE (No. The Albion Hotel ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sara Elizabeth Ponder

(Residence in Baltimore: No. Hotel Albion St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED? (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May, 12th., 1888
(Month) (Day) (Year)

7-AGE, 32 yrs. 9 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Miltin Delaware

PARENTS.

10-NAME OF FATHER, John Ponder

11-BIRTHPLACE OF FATHER (State or Country), Wilmington, Delaware

12-MAIDEN NAME OF MOTHER Lillian Burr

13-BIRTHPLACE OF MOTHER (State or Country), Conn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William H. Ponder
(Address) Ten Hills, Md.

15- Filed FEB 28 1921, 191.... ROBERT F KRAUTER Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 26, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide by poison that
was in Bromo
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) H J Feley M. D.
(Coroner.)
Feb 27, 1921. (Address) 1637 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State 5 mos. ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Milton Del

19-PLACE OF BURIAL OR REMOVAL, Milton, Delaware
DATE OF BURIAL, Feb. 28th., 1921.

20-UNDERTAKER Joseph B. Cook
ADDRESS 1003 N Bal St

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

51298

HEALTH DEPARTMENT—CITY OF BALTIMORE

51298

CERTIFICATE OF DEATH.

REGISTERED NO. 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 East ST.: 5 WARD)

2-FULL NAME Charles E. Mayers

(a) RESIDENCE. No. 228 East ST., 5 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Mayers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Annie Thomas
(Address) 228 East St.

15 Filed FEB 28 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25. 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1921, to Feb 25, 1921, that I last saw him alive on Feb 25, 1921, and that death occurred, on the date stated above, at 1-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.

2-26. 1921 (Address) 120½ Fairmount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 1. 1921
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

CAUSE OF DEATH must be given. See instructions on back of certificate. TION is very important.

D51299 HEALTH DEPARTMENT--CITY OF BALTIMORE D51299

CERTIFICATE OF DEATH

REGISTERED No. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4108 Kate Ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Maynard Miles

(Residence in Baltimore: No. 4108 Kate Ave St.; yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	white	Single

6-DATE OF BIRTH April (Month) 12 (Day), 1888 (Year)

7-AGE 32 yrs. 10 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) New Orleans

PARENTS

10-NAME OF FATHER Theus Miles

11-BIRTHPLACE OF FATHER (State or country) New Orleans La

12-MAIDEN NAME OF MOTHER Alice Herricks

13-BIRTHPLACE OF MOTHER (State or country) Jackson Miss

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert M. Greenfield

(Address) 4108 Kate Ave

FEB 28 1921 Filed ....., 191.. Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 2 (Month) 28 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feby 26, 1921, to Feb 28 1921, that I saw h[illegible] alive on Feb 27, 1921, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Right left lower lobe)

(Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry W. McCarty M. D.

2-28, 1921. (Address) 510 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Former or usual residence New Orleans

19-PLACE OF BURIAL OR REMOVAL New Orleans La

DATE OF BURIAL Feby 28, 1921

20-UNDERTAKER Harry W. Ehlen

ADDRESS 1900 W. North Ave

N. B.-Every item must be answered; if none, state that fact. If unknown, state CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. It is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51300 HEALTH DEPARTMENT—CITY OF BALTIMORE D51300

CERTIFICATE OF DEATH.

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 W. Lanvale St. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Albert Shultz.

(a) RESIDENCE. No. 2023 W. Lanvale St. St., 16 Ward. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? 76 yrs. 10 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Martha A. Shultz.

6 DATE OF BIRTH (month, day, and year) April-4-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: China Riveter.

(b) General nature of industry, business, or establishment in which employed (or employer): Repairing China.

(c) Name of employer: (Self)

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Samuel Shultz

11 BIRTHPLACE OF FATHER (city or town) (State or country): not Known, Pennsylvania.

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not Known, not known.

14 Informant: Mr. S. J. Mehner (Son-in-Law)
(Address) 2023 W. Lanvale St.

15 Filed FEB 28 1921 19 ... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 20, to Feby 28 19 21.

that I last saw him alive on Feby 26 19 21,

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Paralysis agitans

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Charles R Davis M. D.

, 19 (Address) 1108 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: Feb-28- 1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

Information should be given in plain terms, so that it may be understood by the public. CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates. TION is very important.

STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal Cerebral Haemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ø51301

HEALTH DEPARTMENT—CITY OF BALTIMORE

Ø51301

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 Madison Ave. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Poe Carey

(a) RESIDENCE. NO. 1228 Madison Av. ST., 11 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? 82 yrs. 11 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Gibson Carey

6 DATE OF BIRTH (month, day, and year) March-10-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Neilson Poe

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Josephine Clemm

13 BIRTHPLACE OF MOTHER (city or town) Mt. Prospect
(State or country) Balto. Co. Maryland

14 Informant Mrs. Henry M. Thomas (daughter)
(Address) 1228 Madison Av.

15 Filed FEB 28 1921 19 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1921, to Feb 27, 1921, that I last saw her alive on Feb 27, 1921, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Infarction

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. R. Boggs, M. D.

19 (Address) 21 W. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March-1 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

mation should be given in plain terms, so that it may be clearly understood. CAUSE OF DEATH in plain terms, so that it may be clearly understood. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51302 ✓ D51302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~Home~~ Home Retreat St. 38 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Mc Adams

(a) RESIDENCE. NO. Baltimore Md - ST., ... WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? 82 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or ~~WIFE~~ of Mr Mc Adams -

6 DATE OF BIRTH (month, day, and year) Feb 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Cornelius Monison

11 BIRTHPLACE OF FATHER (city or town) not known (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Grady

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country) Ireland -

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Retreat Balto Md

15 Filed FEB 28 1921 19 ROBT. I. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 14 . 1919 . to Feb 27 . 1921 . that I last saw h[illegible] alive on Feb. 26 . 1921 . and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis - R. Hemiplegia

(duration) ? yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia Senile -

Abt - (duration) 4 yrs. 9 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Frank J Flannery , M. D.

, 19 (Address) Mt Hope Retreat Md -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery - DATE OF BURIAL Feb 28 1921.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be classified. Do not use abbreviations or initials. Do not report symptoms, but the disease causing death. If from violence, state the means and nature of injury. Do not state the mode of dying, as shock, exhaustion, etc. Fill all blanks with words or figures, or if there is no information to be had, with a dash. Write plainly with pen and ink. Do not use lead pencil. Do not write on back of certificates. ATION is very important. See instructions on back.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

1 Terminal cerebral
Haemorrhage.

Spec.—8-24-14—M. & T.—2000 Bks.

D51303

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51303

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 4728 Park Heights St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin B. Henderson

(Residence in Baltimore: No. 4728 Park Heights ave. St.; 74 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	married

6-DATE OF BIRTH, ... (Month), 1 (Day), ... (Year)

7-AGE, 74 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk, B.T.C.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Henderson

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Cornelia Buck

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Paul Henderson

(Address) 4728

15- FEB 28 1921 Filed ....., 191.... ROBERT J. KRAUTH Registrar. BURIAL PERMIT Clerk

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) - 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-15- 1921, to 2-27- 1921, that I saw h in alive on Feby 26 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Grippe

..... (Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R.T. Hardesty M. D.

2-27-, 1921 (Address) 914 E. Fay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cem. DATE OF BURIAL, Feb 28 1921

20-UNDERTAKER John O. Mitchell ADDRESS 120 N. Fayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51304

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51304

CERTIFICATE OF DEATH.

144

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 704 S. East Ave. ST.: 1 WARD)

2-FULL NAME Girard Tribull

(a) RESIDENCE. NO. 704 S. East Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 27-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore city

PARENTS

10 NAME OF FATHER Henry Tribull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Magdalene Schubert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Henry Tribull

(Address) 704 S. East Ave.

15 FEB 28 1921 MOSES J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 16th 1921, to Feb 26th 1921, that I last saw him alive on Feb 25th 1921, and that death occurred, on the date stated above, at 6.20 A. m.

The CAUSE OF DEATH* was as follows:

Abscess of cervical glands

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Septic infection

(duration) ..... yrs. ..... mos. 30 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Feb 1/21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Schwatka M. D.

19 (Address) 7348 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Feb. 28 1921.

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Do not use abbreviations or technical terms. Read carefully the back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51305 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D 51305

CERTIFICATE OF DEATH.

152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD) 25

2-FULL NAME Baby Mc Kenna

(a) RESIDENCE. NO. St. Agnes' Hospital WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	Infant			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Agnes Hosp Balto, Md

PARENTS

10 NAME OF FATHER Leo. Mc Kenna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto,

12 MAIDEN NAME OF MOTHER Rose Hoover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Leo Mc Kenna

(Address) 342 E. 25th St

Filed FEB 28 1921

[illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 19 21, to Feb 27, 19 21, that I last saw h[illegible] alive on Feb 27, 19 21, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Increased Intra Cranial Pressure - Due to Birth Instrumental delivery (High forceps)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dudley O'Boyle, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	2/28 1921
20 UNDERTAKER	ADDRESS
Henry W Maas & Son	805 N. Calvert St

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D-5130 6

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-5130 6

REGISTERED NO. 2728

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 Wylie Ave. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Granville Bruce

(a) RESIDENCE. No. 13 Wylie Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary V. Bruce.

6 DATE OF BIRTH (month, day, and year) Feb. 4. 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	0	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Bolts on ship. yard.
(c) Name of employer Balt. Ship Yard

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER Granville Bruce.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary V. Bruce
(Address) 13 Wylie ave

15 Filed FEB 28 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1921, to Feb. 26, 1921, that I last saw h—alive on Feb. 25, 1921, and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis.

(duration) about 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? — Date of

Was there an autopsy? —.

What test confirmed diagnosis?

(Signed) W. T. Seabury, M. D.

2/27, 1921 (Address) 638 Font

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Hill Cem	March 192
20 UNDERTAKER	ADDRESS
Wm F. Evans	[illegible]

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Shamer

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51307 HEALTH DEPARTMENT—CITY OF BALTIMORE D51307

CERTIFICATE OF DEATH. + 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. Eye, Ear & Throat St. 11th W. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory Earl Shamer

(a) RESIDENCE. No. Patapsco, Md. ST., ... WARD. Patapsco Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 19, 1904

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
16	~~June~~ 8	~~19~~ 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Patapsco, Md.

PARENTS

10 NAME OF FATHER Emory Carroll Shamer

11 BIRTHPLACE OF FATHER (city or town) Patapsco (State or country)

12 MAIDEN NAME OF MOTHER Pearl Gill

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co, Md. (State or country)

14 Informant ~~Mrs~~ Mrs. Flo Shamer.

(Address) .....

15 Filed FEB 28 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1921, to 2-27, 1921, that I last saw h[illegible] alive on 2-27, 1921, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Confusion of Speech following injury of Intracranial tissues (duration) ..... yrs. ..... mos. 9 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? Yes Date of 2-27-21

Was there an autopsy? No

What test confirmed diagnosis? Pathology etc.

(Signed) [illegible], M. D.

, 19 (Address) 625 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sandy Mount.	Mar 2 1921
20 UNDERTAKER	ADDRESS
H M Poulson	230 N Bro[illegible]

Burial Permit Issued

CAUSE OF DEATH to be plainly written, and TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51308 HEALTH DEPARTMENT—CITY OF BALTIMORE D51308

CERTIFICATE OF DEATH.

X 41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua F. Magee
Westminster, Md.

(a) RESIDENCE. NO. ..... ST., ... WARD Westminster Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. Blanche Magee

6 DATE OF BIRTH (month, day, and year) Jan 9, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Magee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda Grunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Magee
(Address) Westminster Md

15 Filed FEB 28 1921 ROBERT I. FEUTH Burial Park Register Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25 1921 to Feb. 27 1921,
that I last saw him alive on ..... 19..., and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Sarcoma

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 2-20-21

Was there an autopsy? no

What test confirmed diagnosis? Myocardial Digest

(Signed) J. B. Bronuskas M. D.

2-21, 1921 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sandyville Md.	Mar 2 1921
20 UNDERTAKER	ADDRESS
H M Routson	230 W Fayette

CAUSE OF DEATH in plain terms, so that it may be understood by persons not familiar with the use of certificates. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestines

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 51309

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51309

CERTIFICATE OF DEATH

REGISTERED NO.....

1-PLACE OF DEATH South Baltimore Gen'l. Hospital

CITY OF BALTIMORE: (No. 1213 Light St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeremiah Daley

(a) RESIDENCE. NO. 112 Charlotte, ST., St. Johns, N.B.—Canada. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 6, 1864.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER James Daley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Mary McCardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address)

15 Filed FEB 28 1921 ROBERT E. CRAWFORD Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-25th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1921, to Feb. 25, 1921, that I last saw him alive on Feb. 25, 1921, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at South Balto Gen'l. Hospital

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard L. Colson M. D.

, 19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Brunswick Canada	Feb 28 1921

20 UNDERTAKER Wm. Miles & Son

ADDRESS 1835 E. Pratt

CAUSE OF DEATH in plain terms, so that a stranger can understand. Abbreviations must not be used. Any cause which may be the result of violence must be fully explained. ATTENTION is very important. See instructions on back of certificates.

Rec. 6-9-19 H. P. Co.—1000 Bks.

951310 HEALTH DEPARTMENT—CITY OF BALTIMORE 951310

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 144 Aisquith St. (ST.) 5 (WARD)

2-FULL NAME Annie Leavey

(a) RESIDENCE. NO. 144 Aisquith St. ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hyman Levy

6 DATE OF BIRTH (month, day, and year) — 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jos. L. Levin (Address) 1411 E. Balto St.

15 Filed FEB 28 1921 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1921, to Feb. 28, 1921, that I last saw her alive on Feb. 28, 1921, and that death occurred, on the date stated above, at 12.03 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. J. Green, M. D.

2-28, 1921 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	3/1 1921
20 UNDERTAKER Jos. Levin	ADDRESS 1411 E. Balto St

TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Blks.

Levine

D 51311

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51311

CERTIFICATE OF DEATH.

REGISTERED NO. C 40

1-PLACE OF DEATH Mehrens Hospital,

CITY OF BALTIMORE: (No. 47 N. Caroline ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Levine

(Residence in Baltimore: No. 47 N. Caroline St St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1861 (Year)

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Grocery
(b) General nature of industry, business, or establishment in which employed (or employer). Merchant

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balt St

15- Filed FEB 28 1921, 191... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 28 (Month) (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 20 1921, to Feb 28 1921, that I saw him alive on Feb 28 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of oesophagus

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Louis Lewis M. D.

Feb 28, 1921. (Address) Mehrens Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State 6 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence #47 N. Caroline St

19-PLACE OF BURIAL OR REMOVAL, Mehrens Cemetery — DATE OF BURIAL, 3/2/21

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balt St

important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D51312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51312

CERTIFICATE OF DEATH.

128

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1222 St Mathew ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Albert Seling

(Residence in Baltimore: No. 1222 St Mathew St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE White | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 31 July (Month) (Day), 1898 (Year)

7-AGE, 22 yrs. 8 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Budapest Hungary

PARENTS.

10-NAME OF FATHER, Albert Seling

11-BIRTHPLACE OF FATHER (State or Country) Budapest Hungary

12-MAIDEN NAME OF MOTHER Rosa Mayerhofer

13-BIRTHPLACE OF MOTHER (State or Country), Vienna Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanch Seling

(Address) 1222 St Mathew

15- FEB 28 1921 Filed....., 191.. ROBERT J. KRAUTER Registrar of Records.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 27th Feb Sunday 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 24th January 21, to Feb 27 1921, that I saw him alive on Sunday 27th 1921, and that death occurred, on the date stated above, at 8-15 p.m.

The CAUSE OF DEATH* was as follows:

Tuburculosis

..... (Duration) ....yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) none

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. A. Brehm M. D.

2/27, 1921. (Address) 1023 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence 1028 W Lombard St

19-PLACE OF BURIAL OR REMOVAL, Lauderdale md. | DATE OF BURIAL, Mar. 1., 1921.

20-UNDERTAKER Robt J Turner Inc | ADDRESS 1442 N Broadway

important. See instructions on back of certificate

Form 6-9-19—H. P. Co.—1000 Blks.

D 51313 HEALTH DEPARTMENT—CITY OF BALTIMORE 951313

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hamilton Home Retreat St. 78th Ward) 37

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. Rigney

(a) RESIDENCE. No. Raspburg Md St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Laboring Work.

(c) Name of employer Various -

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Patrick J Rigney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary J Hallenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Records of Mt Hope Retreat

15 Filed FEB 28 1921 BOWERS A KRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 7 1919 to Feb 26th 1921, that I last saw him alive on Feb 26th 1921, and that death occurred, on the date stated above, at 12.10 noon

The CAUSE OF DEATH* was as follows:

Paresis -

Cont'd

abt 3 (duration) or 4 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Melancholia

abt (duration) 3 yrs. 0 mos 0 ds.

18 Where was disease contracted if not at place of death? Probably Baltimore Md -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? W. J.

(Signed) Frank J Flannery, M. D.

Feb 26th 1919 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 1 1921
20 UNDERTAKER Robt J Turner	ADDRESS 1424 W Pratt

Give instructions on back of certificates. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51314

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 E Lafayette ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Wm J Kelly

(a) RESIDENCE. NO. 1500 E Lafayette ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm J Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mable Quade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm J Kelly

(Address) 1500 E Lafayette

15 Filed FEB 28 1921 ROBERT J. KRAUTER Registrar

Burial Permit 01094

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1921, to Feb 27, 1921, that I last saw him alive on Feb 27, 1921, and that death occurred, on the date stated above, at 6 8 m.

The CAUSE OF DEATH was as follows:

Diphtheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Glandular Tuberculosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? Dont know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo D Jones M. D.

, 19 (Address) 1107 Belvidere Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Feb 28 1921

20 UNDERTAKER Wolff & Zumeris

ADDRESS 1442 N Broadway

CAUSE OF DEATH in plain terms, avoiding use of abbreviations or technical terms. Omit words "Cause unknown," "Not known," "Not certain," "Not stated," "Not given," "Not ascertained," "Not known to informant," "Not known to me," "Not known to me at present," "Not known to me at present time," "Not known to me at present time," "Not known to me at present time

Rec.—6-9-19—H. P. Co.—1000 Bks.

D 51315 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51315

CERTIFICATE OF DEATH. X 114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 4 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rachel Ridgely

(a) RESIDENCE. No. New Market, Md. St.. Ward. New Market Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin M. Ridgely

6 DATE OF BIRTH (month, day, and year) Aug 22 1851

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
69.	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benj. M. Ridgely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ely. Chaffee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) D. E. Ridgely M.D. Mercy Hosp.

15 Filed FEB 28 1921 19 ROBERT I. KRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 19 21, to Feb 27, 19 21, that I last saw h alive on Feb 27, 19 21, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis
Gall Stones

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia & Nephritis

Duration yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Yes Date of Feb. 16 '21.

Did an operation precede death? No.

Was there an autopsy?

What test confirmed diagnosis? Specimen.

(Signed) D. E. Ridgely M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Moreno & Bird & Roderick Mar'l	1921
20 UNDERTAKER	ADDRESS
Robert Brookman	Catonsville Hollins

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51316 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51316

CERTIFICATE OF DEATH. 28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A Burton

(a) RESIDENCE. No. 422 W. 25th st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not recorded

6 DATE OF BIRTH (month, day, and year): Feb 4 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory work

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Adelbert Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Effie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records (Address) M.T.H.

15 Filed Robert P. Harrison, Registrar

281921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 25, 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1921, to Feb. 25, 1921, that I last saw her alive on Feb. 25, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum

(Signed) L. S. Fahnestock. M. D.

2-25-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Feb 28 1921

20 UNDERTAKER	ADDRESS
Chenowith & Son	Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51317 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51317

CERTIFICATE OF DEATH. 172

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hop ST.: 15 WARD)

2-FULL NAME John C Donohoe

(a) RESIDENCE. NO. 1703 Ashburton St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the Adelia M. Donohoe.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Stevens S. Donohoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary A. LeGrande

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Joseph A. Donohoe 322 Tennessee Ave-Washington

15 Robert P. Harrison, M.D. Registrar

FEB 8 1921 Burial Permit Clerk.)

CAUSE OF DEATH to be plainly written, without abbreviations. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1920, to Feb 28, 1921, that I last saw him alive on Feb 28, 1921, and that death occurred, on the date stated above, at 3.15 A.m.

The CAUSE OF DEATH* was as follows:

Fracture of Femur

(Cancer)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Fred. Hooper M. D.

(Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	March 2- 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North ave.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51318

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51318

50

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 South Curley ST.; 1 WARD)

2-FULL NAME Martha Ketchum

(a) RESIDENCE. NO. 1024 South Curley ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (Write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Ketchum

6 DATE OF BIRTH (month, day, and year): Dec 7 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ho Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Ebb. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Virginia Sapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): David Ketchum 1024 S. Curley

15 Filed Jan 4 1921 Robert P. Harrison, Registrar

Special Permit Clerk.

TION is very important. See instructions.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Feb. 27, 1924, that I last saw h.. alive on Feb 27, 1924 and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

t

Diabetes Mellitus

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Chemical

(Signed) Wm. McAvoy, M. D.

2/28, 1924 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N.W. Carmel Cemetery	3/2 1924
20 UNDERTAKER: William Cook	ADDRESS: 507 E Nor

D. 51319 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51319

CERTIFICATE OF DEATH. x 130

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1612 Nth. Calvert St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie K. Hubley

(Residence in Baltimore: No. 1612 Nth Calvert St.; yrs., 1 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept (Month) 27 (Day), 1851 (Year)

7-AGE, 69 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). York Penna

PARENTS.

10-NAME OF FATHER. Ralph Sanders

11-BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12-MAIDEN NAME OF MOTHER. Margaret Hildebrandt

13-BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexandra Hubley

(Address) Thomasville Penna

15- Robert P. Harrison,

Filed ....., 191.....

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7 (Month) (Day), 1914. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Carcinoma of Female Organs

(Duration).....yrs.....mos.....ds.

(Signed) .....M. D.
(Coroner.)

Oct 8, 1914. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, York, Pennsylvania

DATE OF BURIAL, Oct 11, 1914

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave.

1st Riley Burial

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51320

CERTIFICATE OF DEATH.

119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3414 Auchentorly Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Seligman

(a) RESIDENCE. No. 3414 Auchentorly Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 12 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Leo L. Seligman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Hannah Hamburger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Leo L Seligman

(Address): 3414 Auchentorly

15 Filed 19 Robert P. Harrison, Registrar

B281921

Burial Permit Cleared

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to Feb 27, 1921,

that I last saw h[illegible] alive on Feb 27, 1921,

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows: Streptococcus Viridans

(duration) ... yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary): Stenosis - Cardiac Exhaustion

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Blood culture

What test confirmed diagnosis?

(Signed) Arthur Hebb, M. D.

, 19 (Address) 330 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Alta Sharon	3/2nd 1921

20 UNDERTAKER: Harry Goodheim ADDRESS: 1[illegible] Park Ave

TION IS very important.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

The child had had a bad heart since birth. Acute Nephritis Primary Cause of death.

D.51321 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51321

CERTIFICATE OF DEATH.

175-001 REGISTERED NO. C.

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) St. Joseph Hospital ST.: 7 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anders Lind

(Residence in Baltimore: No. 716 N. Montford Ave

110
St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Feb 11th, 1862
(Month) (Day) (Year)

7-AGE, 59 yrs. mos. 17 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknow

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknow

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sophia Daub

(Address) 716 N Montford Ave

15-

Filed ..., 191.. Robert P. Harrison,
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an August (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to Ins. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Automobile Accident
Type-Pneumonia
(Duration) yrs. 4 mos. 27 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. C. Blade M. D.
(Coroner.)
8/27/21 (Address) 1428 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery
DATE OF BURIAL, August 1st, 21

20-UNDERTAKER, Jas C Muller
ADDRESS 2334 Jefferson

important. See instructions on back of certificate.

FEB 53192

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51322 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51322

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 813 Harlem Avenue ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard T. Martin

(a) RESIDENCE. No. 813 Harlem Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estelle Clark

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman-Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery Business

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George A. Martin

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anne Coates

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant George A. Martin
(Address) 1604 N. Calvert Street

15 Filed ..... 19.... Registrar

3281921 Robert P. Harrison
Burial Permit Clerk.

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1921, to Feb 26/21, 19....,

that I last saw h.... alive on Feb 26, 1921,

and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Conrad Heinbecker, M. D.

, 19 (Address) 24 E Fallon Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	3/1, 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.51323 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.51323

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S. Sharp ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy S. Gantt

(a) RESIDENCE. NO. 607 S Sharp ST. 22 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/10/20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas R. Gantt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sidonia Burrows

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sidonia Burrows
(Address) 607 S Sharp St.

15 Filed ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

B281921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27th 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/25 1921, to 2/27 1921, that I last saw her alive on 2/27 1921, and that death occurred, on the date stated above, at 12-Noon m.

The CAUSE OF DEATH* was as follows:

Postmortem Infect - Cat.

2 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Deficient milk Supply From birth
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Chas Bowley M. D.

2/28/21 .19 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct.	March, 1921
20 UNDERTAKER Smith L. Frary & Son	ADDRESS 105 W. Mont. from Lay St

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51324 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51324

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Cranwell

(a) RESIDENCE. NO. 300 Block S. Eden St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Jos. Cranwell

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cassiday

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Anna Harris.

(Address) 234 S Eden St

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1921, to Feb 26, 1921, that I last saw h.r alive on Feb 26, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) - yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C. Marcus, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	Mch 2nd 1921
20 UNDERTAKER	ADDRESS
Lilly + Zeiler	403 S. Wolfe St

TION is very important. See instructions.

281921 Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51325 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.; 10 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Aikens

(Residence in Baltimore: No. ..... St.; .....yrs,,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 10 (Day), 1875 (Year)

7-AGE, 45 yrs. 11 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. J. Shreeve

(Address) Warden Maryland Penitentiary

15- Robert P. Harrison, JOHNS

Filed....., 191.....

B 28192 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 19 1920, to February 16 1921, that I saw him alive on February 15 1921, and that death occurred, on the date stated above, at 9.04 a.m.

The CAUSE OF DEATH* was as follows:

Toxemia - Exhaustion Cardiac failure

Bronchitis - Uremia

..... (Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY. Pyorrhoea Alveolaris
(Secondary)

..... (Duration) .....yrs. 1 mos. 27 ds.

(Signed) William J. Schwartz M. D.

Feb 14, 1921 (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 2 mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Asbury Park, N. J. (Hotel Dale)

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER ~~Tydoor~~

ADDRESS

FEB 20 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51326 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51326

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 Lemmon St ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannie Entzel

(a) RESIDENCE. NO. 721 Lemmon St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 1809

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Selig G. Entzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Isenbergers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J. Entzel (Address) Funeral apt

15 Filed Robert P. Harrison, Registrar

B281921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1921, to Feb. 27, 1921, that I last saw h[e] alive on Feb 26, 1921, and that death occurred, on the date stated above, at 29 m.

The CAUSE OF DEATH* was as follows:

Status epilepticus

epilepsy - 30 years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) oedema of lungs (duration) yrs. mos. 2 ds.

18 Where was disease contracted ✓ If not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J Frederick Lentz, M. D.

2/27. 1921 (Address) 2040 Linton Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Har Sinai	March 1st 1921
20 UNDERTAKER	ADDRESS
Chas Sondheim	1804 W Royal Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51327 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51327

CERTIFICATE OF DEATH.

REGISTERED NO. 122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3617 Fairview Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabel Austrian Heller

(a) RESIDENCE. No. 3617 Fairview Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles A. Heller

6 DATE OF BIRTH (month, day, and year): July 4th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Charles Austrian

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Babette Dreifus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Heller
(Address) 3617 Fairview Ave

15 Filed ..... 19.. Robert P. Harrison, Registrar

FEB 28 1921 [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1920, to July 27, 1921, that I last saw her alive on July 26, 1921, and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Emaciation

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Enterotoxemia Pyelitis + Nephritis Chronic

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Arthur L. Lyhamfield, M. D.

7/27. 1921 (Address) 2006 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	July 29th 1921
20 UNDERTAKER	ADDRESS
Ward & Sondheim	1128 W. Lexington St

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51328 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51328

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 E. North Ave. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace L. Jordan.

(a) RESIDENCE. No. 1321 E. North Ave. ST., WARD.

(Usual place of abode) Lifetime.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Jordan.

6 DATE OF BIRTH (month, day, and year) Nov. 27 1865.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	3	-----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Samuel James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Eliza Stephens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Charles Jordan

(Address) 1321 E. North Ave.

15 Filed ....., 19.... Robert P. Harrison, Registrar

2 8 1921 Burial Permit Clerk.

TION is very important. See instructions on reverse side.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to Feb 25, 1921, that I last saw h Gr alive on Feb 20, 1921, and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Cardiac Dilatation

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Disease.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Michael A. Abrahms, M. D.

, 19 (Address) 1360 Eutaw place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery.

DATE OF BURIAL 3/1/21 19

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 118 W. Mt Royal ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51329 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51329

CERTIFICATE OF DEATH.

REGISTERED NO. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 S Broadway ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Pettitt

(Residence in Baltimore: No. 807 S Broadway St. 4y yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
W	W	Sing

6-DATE OF BIRTH, Dec 1 (Month) (Day) 1916 (Year)

7-AGE, 4 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Later
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Dan Kenn

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Dan Kenn

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Duffy

(Address) 807 S Broadway

15-

Filed ....., 19.. Robert P. Harrison, Registrar.

FEB 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 27, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 25 1921, to Feb 27 1921, that I saw him alive on Feb 27 1921, and that death occurred, on the date stated above, at 7.50 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(Duration) yrs. mos. ds.

(Signed) A. V. Amussano M. D.

Feb 28, 1921 (Address) 7 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Mar 3, 1921

20-UNDERTAKER Robt J Turner ADDRESS 1742 N Pine

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D. 51330 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51330

CERTIFICATE OF DEATH. 18

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY ● BALTIMORE: (No. 1007 Belvedere Ave ST. 28 WARD)

2-FULL NAME Lucy Ann Swann

(a) RESIDENCE. NO. 1007 Belvedere Ave ST., 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of G Edwin Swann

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 80				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) Fredericksburg Va

PARENTS

10 NAME OF FATHER Horace Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant H. P. Swann
(Address) 1007 Belvedere Ave

15 [illegible] Robert P. Harrison, Registrar

B 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27. 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1921, to Feb 27, 1921, that I last saw h[illegible] alive on Feb 27. 1921, and that death occurred, on the date stated above, at 5 P- m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia and Facial Erysipelas Coexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Accidental fall downstairs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James S Ashurst, M. D.

2/28. 1921 (Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 1921
20 UNDERTAKER	ADDRESS
H Fleckenstein & Sons	Penna Ave

UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

I am well acquainted with this family and believe this a pure case of accident. Erysipelas developed in an [illegible] abrasion on forehead sustained in the fall

D.51331 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51331

CERTIFICATE OF DEATH. 155

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital St.: 16 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kathryn Muller

(Residence in Baltimore: No. 916 N Gilmor St.: yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, Sept 27, 1891 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
29 yrs. 5 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, W.A. Mayes

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H Muller

(Address) 916 N Gilmor St

15- Robert P. Harrison,

Filed FEB 28 1921 1921 Burial Permit Clerk.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 28, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury
Poisoning Self admin
Natural Suicide

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. 2 ds.

(Signed) James M Fenton M. D. (Coroner.)

Feb 28 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Franklin Sq Hos In the of death....yrs....mos. 6 ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

916 N Gilmor St

Former or usual residence 916 N Gilmor St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Weyers Cave - Va	March 1921

20-UNDERTAKER	ADDRESS
William Cook	302 E. North Ave

important. See instructions on back of Certificate

D. 51332 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51332

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1528 N. Spring ST.: 9 WARD) 79 REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Charlton

(Residence in Baltimore: No. 1528 N. Spring St.) Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Feb 13, 1847 (Month) (Day) (Year)

7-AGE, 74 yrs. — mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Barrister
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Geo W. Charlton

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Mary A. Philpsine

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W. Charlton

(Address) 1528 N. Spring

15- Robert P. Harrison, Registrar.

FEB 24 1921, 191.....

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 27, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs.....mos.....ds.

(Signed) ..... M. D. (Coroner)

2-28, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, 3/1, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

N. Amey 2900 E. Balto St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51333 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51333

CERTIFICATE OF DEATH.

REGISTERED NO. 15-502

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 McHenry ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Stern

(a) RESIDENCE. NO. 1912 McHenry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) 9 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65 ✓			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Flores Leeser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rachel Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Robert Stern
(Address) 1912 McHenry ave

15 Filed ....., 19 .....

Robert P. Harrison, Registrar

3 8 1921 Burial Permit Clerk.

"TION is very important. See

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 28th, 1919, to Feb 28th, 1921, that I last saw her alive on Feb 28th, 1921, and that death occurred, on the date stated above, at 12.05 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 0

Did an operation precede death? No Date of 0

Was there an autopsy? No

What test confirmed diagnosis? Chemical & Microscopical

(Signed) August Hom, M. D.

, 19 (Address) 40 E 25th st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai Cem — DATE OF BURIAL 3/1/1921

20 UNDERTAKER J. Ahrens & Co — ADDRESS 1621 Madison

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51334 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51334

CERTIFICATE OF DEATH.

412

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3504 E. Baltimore ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta A. Mulligan

(a) RESIDENCE. NO. 3504 E. Baltimore ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Mulligan

6 DATE OF BIRTH (month, day, and year) Dec. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER John Kahl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant James E. Mulligan
(Address) 3504 E. Baltimore st

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26/21

17 I HEREBY CERTIFY, That I attended deceased from 6/25/20, 19..., to 2/26/21, 19..., that I last saw h— alive on 2/26/21, 19..., and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix
Uni Rectum

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) none

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms

(Signed) [illegible], M. D.

, 19 (Address) 719 Walbert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harford Road H.G. Cross Cemetery	3-1 1921

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Balto St.

TION is very important. See instructions on back.

Form 6-9-19—H. P. Co.—1000 Blks.

D51335 HEALTH DEPARTMENT—CITY OF BALTIMORE D51335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Belnord Ave ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hotis

(a) RESIDENCE. NO. 523 N Belnord Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hotis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Hodicka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant James Hotis (Address) 523 N Belnord Ave

15 [illegible] MAR 1 - 1921 ROBERT J. KRAUSE Burial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25 1921

17 I HEREBY CERTIFY, That I attended deceased from February 25, 1921 to February 25, 1921

that I last saw h alive on February 25, 1921

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) Willard P Pyeatt M. D.

(Address) 80 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 1 1921

20 UNDERTAKER Frank Brack Son

ADDRESS 1906 Eastland

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51336

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2326 Jefferson ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hemec

(a) RESIDENCE. (No.) 2326 Jefferson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Goldie Hemec

6 DATE OF BIRTH (month, day, and year) Aug 11 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman for

(c) Name of employer J. J. Alea

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Hemec

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Antonia Fanez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Goldie Hemec (Address) 2326 Jefferson

15 MAR 1 - 1921 ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1921, to Feb 28, 1921

that I last saw h live on 19,

and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Mitral stenosis, Pulmonary

Infarction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. F. [illegible] M. D.

Jan 28 1921 (Address) 810 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 3 1921
20 UNDERTAKER	ADDRESS
Paul F. Brochu Son	1906 E. Pr

CAUSE OF DEATH. See instructions on back of Certificate. ATTENTION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Houska

951337 HEALTH DEPARTMENT—CITY OF BALTIMORE

Loveska

91 D 51337

CERTIFICATE OF DEATH.

6

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 N Castle St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Centonee Houska

(Residence in Baltimore: No. 134 N Castle St.; Unknown yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Unknown (Month) ..... (Day), 1873 (Year)

7-AGE, 48 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Victor Shefka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Wm Kroon

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jeffrey Houska

(Address) 134 N Castle St

15- Filed MAR 1 - 1921 ROBERT A KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 20 1921, to Feb 26 1921 that I saw h[illegible] alive on Feb 25 1921 and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) F F Burnside M. D.

2-[illegible], 1921 (Address) 2001 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Mar 2, 1921

20-UNDERTAKER Frank Bracklow — ADDRESS 1916 Carlton

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51338

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S Chester ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Idnarfa Nowakowska

(a) RESIDENCE NO. 410 S Chester ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Nowakowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Rajkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Frank Nowakowski 410 S Chester

15 MAR 1 - 1921 [illegible] Registrar

[illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/23 1921, to 2/27 1921,

that I last saw h.r alive on 2/28 1921,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia & Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jos D Quitsch, M. D.

2/28 1921 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	March 1 1921

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

TION is very important. See instructions on back

D51339 HEALTH DEPARTMENT—CITY OF BALTIMORE D51339

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. S/S Sudbury, Pier 6 Locust Point St. 2 WARD)

REGISTERED NO. C 186

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Kamieniski.

(Residence in Baltimore: No. 717 S. Bond St. 9 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Married

6-DATE OF BIRTH, November 2nd, 1878, 1
(Month) (Day) (Year)

7-AGE	If LESS than 1 day,
42 yrs. 3 mos. 24 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Poland.

PARENTS.

10-NAME OF FATHER: Joseph Kamieniski.

11-BIRTHPLACE OF FATHER (State or Country): Poland.

12-MAIDEN NAME OF MOTHER: Machalina Rajkoska

13-BIRTHPLACE OF MOTHER (State or Country): Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stepan Domzalski (brother in law.)

(Address) 712 S. Wolfe St.

15- Filed MAR 1 - 1921, 191 ROBERT J KRAUTER Registrar

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 26th, 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall of bar of copper on his head. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto K. Reinhardt M. D.
(Coroner.)

Feb. 27, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 2, 1921

20-UNDERTAKER	ADDRESS
John M. Weber	1803 Bank St

important. See instructions on back of certificate.

Kutz

D 51340

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51340 HEALTH DEPARTMENT—CITY OF BALTIMORE 28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2500 Fleet St ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME agnes Kutz

(a) RESIDENCE. No. 2500 Fleet St ST., WARD.

(Usual place of abode) (if nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Kutz

6 DATE OF BIRTH (month, day, and year) Jan 28 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Anthony Warcenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Stefanski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Henry Kutz 2500 Fleet

15 FILED MAR 1 - 1921 ROBERT J. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1921, to Feb 28 1921, that I last saw h[illegible] alive on Feb 27 1921, and that death occurred, on the date stated above, at 4:19 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Rungee M. D.

2-28 1921 (Address) 8001 Pulaski Hiway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 3 1921

20 UNDERTAKER John A Weber ADDRESS 1803 Bank St

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51341 HEALTH DEPARTMENT—CITY OF BALTIMORE D51341

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat St. 10th Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Donohue

(a) RESIDENCE. No. 934 Valley St. St., Ward. Unknown.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. ds. How long in U. S., if of foreign birth? Don't Know yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Mr Donohue

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat Baltimore Md.

15 Filed MAR 1 - 1921 19 ROBERT S. SLATER Registrar

THIS is very important. See instructions on reverse side.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28th 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to Feb 28th 1921, that I last saw her alive on Feb 28th 1921, and that death occurred, on the date stated above, at One P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (Sudden)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Melancholia

Abt (duration) 3 yrs. 4 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Feb 28th 1921 (Signed) Frank J Flannery, M. D.

(Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar 3 1921
20 UNDERTAKER	ADDRESS
Wisher Slater & Son	132 W Pratt

englelin

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51342

D51342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3817 Falls Road ST. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen J. Tunney

(a) RESIDENCE. No. 3817 Falls Road ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Francis P. Tunney

11 BIRTHPLACE OF FATHER (city ~~or town~~) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Boone

13 BIRTHPLACE OF MOTHER (city ~~or town~~) Baltimore
(State ~~or country~~)

TION is very important. Use additional sheet if necessary.

14 Informant Nellie Tunney
(Address) 3817 Falls Road

15 Filed MAR 1 - 1921 19.. ROBERT J. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1913, to Feb. 28, 1921, that I last saw h[illegible] alive on Feb. 28, 1921, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Ptomaine Poisoning over

(duration) ..... yrs. ..... mos. 3. ..... ds.

CONTRIBUTORY: Enteric Colitis
(Secondary)

(duration) ..... yrs. ..... mos. 4 ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical signs & symptoms

(Signed) C. J. Connybeare, M. D.

2-27, 1921 (Address) 3201 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar 1921
20 UNDERTAKER	ADDRESS
Martin Fisher & Son	827 W Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

~~D 5 1343~~ HEALTH DEPARTMENT—CITY OF BALTIMORE ~~D 5 1343~~ 28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 872 Pierce ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda Hawkins

(a) RESIDENCE. No. 872 Pierce ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col'd	Mar'd

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Walter Hawkins

6 DATE OF BIRTH (month, day, and year) June 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home 037
(b) General nature of industry, business, or establishment in which employed (or employer): at home
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Plymouth N. C.

PARENTS

10 NAME OF FATHER Jas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Lucy Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Walter Hawkins
(Address) 872 Pierce

15 Filed MAR 1 - 1921 19 ROBERT F KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1921, to Feb 28, 1921, that I last saw h[illegible] alive on Feb 28, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) J Norwood, M. D.

Feb 28, 1921 (Address) 987 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Plymouth N. C.	3/1/21
20 UNDERTAKER	ADDRESS
Mrs Chas B Jones	N Pine St

THIS IS very important. See instructions.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51344 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51344

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 Pinkney Place ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Gentzraft

(a) RESIDENCE. No. 431 Pinkney Place ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Medord

6 DATE OF BIRTH (month, day, and year) July 9th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Gentzraft

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Shelton

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mary Gentzraft
(Address) 431 Pinkney Place

15 FILED MAR 1 - 1921 ROBERT I. CARTER Registrar
Burial Permit Obtd

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20th, 1921, to Feb 26, 1921, that I last saw her alive on Feb 26, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Headache & Blood Pressure

(Signed) Joseph T. Herring, M. D.

, 19 (Address) Walbrook after 1st Nov Mulberry E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 2. 1921

20 UNDERTAKER John J Fields — ADDRESS 1200 W Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

Berry Cohen

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51345 — D51345 — 92 — D51345

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2404 Francis ST.: 13 WARD)

2-FULL NAME Berry Cohen

(a) RESIDENCE. NO. 2404 Francis ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Emanuel Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Weinstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant L. Cohen
(Address) 1929 W. Pratt st.

15 Filed MAR 1 - 1921 ROBERT J. [illegible] Registrar
Burial Permit Issued

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1921, to Feb 28, 1921, that I last saw h[illegible] alive on Feb 28, 1921, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Joseph Glickman, M. D.

(Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd	March 1921
20 UNDERTAKER	ADDRESS 1127
Mat Feinstein	E Balto st

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51346

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 646 Mosher ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Larenia Hanson

(a) RESIDENCE. No. 646 Mosher ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Richard Hanson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Burley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Hanson
(Address) 646 Mosher St

15 Filed MAR 1 - 1921, 19 ROBERT I. LEA[illegible]
Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1920, to Feb. 27, 1921, that I last saw h. alive on Feb. 27, 1921, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Arteri-sclerosis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edw. J. Schaller, M. D.

2/27 1921 (Address) 1230 Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Mch 2 1921
20 UNDERTAKER	ADDRESS 142
John H. Toadvine	Wash St

Spec. 6-9-19—H. P. Co.—1000 blks.

D51347 HEALTH DEPARTMENT—CITY OF BALTIMORE D51347

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 W. Franklin ; 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Pinder

(a) RESIDENCE. NO. 1704 W. Franklin ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah F. Pinder

6 DATE OF BIRTH (month, day, and year) Unk 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 086

(b) General nature of industry, business, or establishment in which employed (or employer) C & P. Telephone

(c) Name of employer Bldg. Balto.

9 BIRTHPLACE (city or town) ..... (State or country) Balto.

PARENTS

10 NAME OF FATHER Draper Pinder

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Sini Bantum

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Fred. Pinder (Address) 704 W. Franklin St

15 Filed MAR 1 - 1921 19.. Registrar

FOREST I. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1921, to Feb 21, 1921, that I last saw h[illegible] alive on Feb 20, 1921, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilation Valvular

(duration yrs. mos. 7 ds.)

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 704 W Franklin

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles F. Fowler M. D.

1921 (Address) 712 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. — DATE OF BURIAL Mch 1 1921

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Ostrich St

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

051348 HEALTH DEPARTMENT—CITY OF BALTIMORE 051348

CERTIFICATE OF DEATH. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Brevard St.: 11 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allie Fay Wilson

(a) RESIDENCE. No. 906 Brevard St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Brooks Wilson

6 DATE OF BIRTH (month, day, and year) Aug 2-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo W Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Alice Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo W. Fox

(Address) 906 Brevard St

15 Filed MAR 1 - 1921 ROBERT A KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 25 1921, to Feb 27, 1921,

that I last saw h.. alive on Feb 27, 1921,

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? H.B. Isolated

(Signed) Paul Bryon, M. D.

2/25 1921 (Address) 1437 Pa. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Metzerott M E	Mch 1921
20 UNDERTAKER	ADDRESS
Wm Bud	502 E Balto

CAUSE OF DEATH. Information must be given by the physician or coroner to the Registrar of Vital Statistics. ATTENTION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51349

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 447 S. 12th ST.; 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Seidman

(a) RESIDENCE. NO. 1016 E Fountain ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not employed

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Meister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Zintsen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. D. Hurkofsky (Address) 447 S. 12th St.

15 Filed MAR 1 - 1921 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1921, to Feb 28, 1921, that I last saw h alive on Feb 28, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema & Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1016 E Fountain St

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John R Abercrombie M. D.

, 19 (Address) 1316 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	March 1 1921

20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D51350 HEALTH DEPARTMENT—CITY OF BALTIMORE D51350

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ~~Res.~~ Hebrew Hospital REGISTERED NO. C 114

CITY OF BALTIMORE: (No. Monument St ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Sarah Weiner

(Residence in Baltimore: No. 107 Harrison St St.; ~~38~~ 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F.	W.	Widow

6-DATE OF BIRTH, — — 1883
(Month) (Day) (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Simon Molmiffka

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Ethel Mans

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levi

(Address) 1411 E. Balto

15- MAR 1 - 1921 ROBERT I. KRAUTER 191
Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH March 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 27 1921, to March 1, 1921, that I saw her alive on March 1 1921, and that death occurred, on the date stated above, at 5 40 a.m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Mental~~ Peritonitis

(Duration) yrs. mos. ds.

(Signed) Charles S. Levy M. D.

3-1-, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State 15 yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 107 Harrison St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel DATE OF BURIAL, March 1 1921

20-UNDERTAKER Jos Levi ADDRESS 1411 E. Balto

Spec.—8-24-16—M. & T.—2000 Blks.

D 51351

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2836 Hanford Ave ST.; 9 WARD) 120

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm P Sudsbury

(Residence in Baltimore: No. 2836 Hanford Ave St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Feby 25, 1861
(Month) (Day) (Year)

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Marble Cutter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm P Sudsbury

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Jane Simpson

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm Sudsbury

(Address) 2836 Hanford Ave

15-

Filed ..., 191.. [illegible] Registrar.

MAR 1 - 1921

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feby 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 22nd 1921, to Feb 27th 1921, that I saw him alive on Feb 26th 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory Hopeless

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wilbur H Costen M. D.

Feb 28th 1921 (Address) 300 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cemetery — DATE OF BURIAL. Feby 28, 1921.

20-UNDERTAKER Robt J Turner — ADDRESS 1422 N. Bway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51352 HEALTH DEPARTMENT—CITY OF BALTIMORE D51352

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 25 151 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Gayleard.

(a) RESIDENCE. No. Cascade Ave. Washington Park. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 6 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) University Hospital Baltimore Maryland.

PARENTS

10 NAME OF FATHER Walter Gayleard.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Margaret Watkins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Father Walter Gayleard (Address) Cascade Ave Washington Park.

15 Filed MAR 1 - 1921 [illegible] Registrar

Burial Permit Issued

CAUSE OF DEATH in plain words. Do not use abbreviations or technical terms. See instructions on back of certificates. DESCRIPTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26 1921

17

I HEREBY CERTIFY, That I attended deceased from February 26, 1921, to February 26, 1921, that I last saw him alive on February 26, 1921, and that death occurred, on the date stated above, at 6:55 p.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Premature

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? none

(Signed) J. Marion Reese, M. D.

2-26, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	2/27 1921

20 UNDERTAKER John Cowan & Son

ADDRESS 908 Hollins St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51353

CERTIFICATE OF DEATH.

138

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Gaylard

(a) RESIDENCE. No. Cascade Ave Washington Park ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Gaylard

6 DATE OF BIRTH (month, day, and year) December 6 1898

7 AGE	Years	Months	Days	If LESS than 1 day ___ hrs. or ___ min.
	22	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER William Watkins

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Husband Walter Gaylard. (Address) Cascade Ave. Washington Park

15 Filed MAR 1 1921 [illegible] Registrar

Burial Permit Given

CAUSE OF DEATH in plain words. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26 1921

17

I HEREBY CERTIFY, That I attended deceased from February 26 1921, to February 26 1921, that I last saw her alive on February 26 1921, and that death occurred, on the date stated above, at 2:20 p.m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) 9 mos. yrs. 9 mos. ... ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? yes Date of February 26 21.

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. Marion Reese, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	3/2/ 1921
20 UNDERTAKER John J. Cannon & Son	ADDRESS 501 Hollins St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-09 D51354

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 N. Pine St., 20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Neale M. Dorsam

(a) RESIDENCE. No. 129 N. Pine St., Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 15 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Elmer H. Dorsam

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Lydia Mellet

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Elmer H. Dorsam
(Address) 129 N. Pine St.

15 Filed MAR 1 1927 [illegible] KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to Feb 27, 1927, that I last saw h[illegible] alive on Feb 26, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Clarence [illegible], M. D.

Feb 28, 1927 (Address) 47 N. Hanover Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Mar 1 1927
20 UNDERTAKER	ADDRESS
H. B. Hoppert	2236 Frederick Ave

CAUSE OF DEATH in plain terms, so that it may be understood by persons not familiar with technical terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51355 HEALTH DEPARTMENT—CITY OF BALTIMORE D51355

CERTIFICATE OF DEATH. ×50

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1903 Hollins ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella March Bidgood

(a) RESIDENCE. No. 1903 Hollins ST., WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas A. Bidgood

6 DATE OF BIRTH (month, day, and year) Dec 25 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Philip March

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ellen Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Grace Bidgood

(Address) Churchland Va.

15 FILED MAR 1 - 1921 BUREAU OF VITAL STATISTICS Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1921, to Feb 27, 1921, that I last saw her alive on Feb 27, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 1 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? — Date of

Was there an autopsy? I

What test confirmed diagnosis? Clinical

(Signed) R Hills Hemming, M. D.

3/1, 1921 (Address) 2000 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	3/1 1921

20 UNDERTAKER Geo A. Herbig ADDRESS Balto. Pulaski st

TION is very important. See instructions on back of ck of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51356 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51356

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Druid Ave ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Jones

(a) RESIDENCE. NO. 913 Druid Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Mar.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Mary Jones

(Address) 913 Druid Ave

15 MAR 1 - 1921 BOTLEY & KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to Feb 27, 1921,

that I last saw h alive on Feb 24, 1921,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cancer, Acrophagus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Malignant

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Mass

(Signed) J Norwood, M. D.

Feb 28, 1921 (Address) 934 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 1 1921
20 UNDERTAKER	ADDRESS 114 S.
Brown & Freeland	Schroder

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51357 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51357

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1456 Riverside ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Slater Hunt

(Residence in Baltimore: No. 1456 Riverside ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem	White	single

6-DATE OF BIRTH, 2 (Month) 28 (Day), 1921 (Year)

7-AGE, ...yrs. 9th Postal mos. ....ds. If LESS than 1 day, ...hrs. or N. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER. Hunt F Hunts

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Mary E. Slater

13-BIRTHPLACE OF MOTHER (State or Country). Lancaster co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hunt F. Hunts

(Address) 1456 Riverside Av

15- MAR 1 - 1921 191. ROBERT J. KRAUTER Burial permit issued. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2.28 1921, to 2.28 1921, that I saw her alive on 2.28 1921, and that death occurred, on the date stated above, at 3.15 m.

The CAUSE OF DEATH* was as follows:

Dystocia

6 hours (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ——— (Duration) ....yrs. ....mos. ....ds.

(Signed) L. F. Linthicum M. D.

2.28.21 (Address) 1132 E Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Cross Cem	3-1-, 1921

20-UNDERTAKER	ADDRESS
E. B. Hanke	115 E. Fort Ave

Important. See instructions on back of Certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 51358

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St.: 4 Ward)

REGISTERED NO. 282

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archie Morris

(a) RESIDENCE. No. 245 Pearl St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Morris

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS

10 NAME OF FATHER Abram Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) U.T.H.

15 Filed MAR 1 - 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1920, to Feb. 27, 1921, that I last saw him alive on Feb. 26, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. J. Rigney. M. D.

2-28-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS MAR. 1 1921

Per. Wm. E. WOODALL

TION is very important. See instructions on back of certificates.

D51359 (Pierce) HEALTH DEPARTMENT—CITY OF BALTIMORE D51359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 152

CITY OF BALTIMORE (No. 1311 Smith St. St.; 16 WARD)

2-FULL NAME Not Named (Baby Pierce)

(Residence in Baltimore: No. 1311 Smith St. St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: C

5-SINGLE, ~~MARRIED~~ WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ... Feb. 27, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 4 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(h) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER: Stephen Pierce

11-BIRTHPLACE OF FATHER (State or Country): N C

12-MAIDEN NAME OF MOTHER: Cecilia Cochran

13-BIRTHPLACE OF MOTHER (State or Country), N C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- MAR 1 - 1921 Filed ..... 191.. Burial Permit [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2/28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonat. 4 hrs.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Wade M. D.
(Coroner.)

2/28/21 (Address) 1432 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
HOPKINS HOSP	
20-UNDERTAKER Commissioner Health	ADDRESS MAR 1 1921

Par. Wm. E. WOODALL

No. 51360

S: 6-9-19—H. P. Co.—1000 Bks.

No. 51360 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 E Biddle ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph T. Hamilton

(a) RESIDENCE. NO. 715 E Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. 27 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Aurelia A Hamilton

6 DATE OF BIRTH (month, day, and year) Jan 28th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	X	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) H M. R R Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph E Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Hathaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Aurelia A Hamilton 715 E Biddle St

15 Filed 1-1921, 19 Robert P. Harrison, Registrar [Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1921

17 I THEREBY CERTIFY, That I attended deceased from Feb 27, 1921, to Feb 27, 1921, that I last saw him alive on Feb 27, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac asthma

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chr Parenchymatous Nephritis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Wm P Geraghty, M. D.

, 19 (Address) 703 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 2nd 1921
20 UNDERTAKER	ADDRESS
George Schulling & Sons	1126 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51361 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51361

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Municipal Tuberculosis Hospital St., 8 WARD)

REGISTERED NO. 34

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Willer

(a) RESIDENCE. No. 1207 Chatham st. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Will Willer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Willer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed 19 Robert P. Harrison, Registrar
R1-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 19 21, to Feb. 28, 19 21.
that I last saw him alive on Feb. 27, 19 21.
and that death occurred, on the date stated above, at 12.30 P. M.
The CAUSE OF DEATH* was as follows:

Tuberculous osteomyelitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. N. Fahnbulch. M. D.
2-28-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery.	March 2 1921
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

(over - See affadavits)

D. 51362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51362

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1006 N. Bond ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luigi Mangione Di Dio

(a) RESIDENCE. No. 1006 N. Bond ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugenia Peta

6 DATE OF BIRTH (month, day, and year) March 7-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
41	11	23		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Liborio Mangione

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Angela Bonn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Eugenia Peta
(Address) 1006 N. Bond. St

15 Filed APR 1 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1921, to Feb. 28, 1921, that I last saw him alive on Feb. 27, 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) A. Palmisano, M. D.

1-3, 1921 (Address) 75 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	March 2 1921
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave

TION is very important. See instructions on back of certificate.

on file in the Office of the Health Department is NOT CORRECT, whereas it should be "Luigi Mangione Di Dio"

I here make affidavit that the above is correct and that the record should be changed. The correct name is

(Luigi Mangione Di Dio)

Eugenia Mangi

Di Di

Sworn to and subscribed before me t

6th day of July, 1921.

Marion T. Shea

The name of Luigi Mangione as shown on the Certificate of Deat
on file in the Office of the Health Department is NOT CORRECT,
whereas it should be "Luigi Mangione Di Dio"

I hereby make affidavit that the above is correct and that
the record should be changed. The correct name is
(Luigi Mangione Di Dio)

A. Salvemini

Sworn to and subscribed before me
6th day of July, 1921

Marion T. Knight
Notary Pub

Spec.—8-24-14—M. & T.—2000 Bks.

D.51363 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51363

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 E Lombard ST.; 7 WARD) REGISTERED NO. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C Dietz

(Residence in Baltimore: No. 1929 E. Lombard St ST.; 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, Aug 28, 1840 (Month) (Day) (Year)

7-AGE. 80 Years. yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, R. Ilgan.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Mary C. Ilgan.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Dietz

(Address) 1929 E. Lombard St

15-

Filed MAR 1 1921 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb. 28, 1921 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 28 1921, that I saw h alive on Feb 27 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) C Clinton Wades M. D.

3/1/21, 191... (Address) 1443 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, March 2, 1921

20-UNDERTAKER George F. Burton

ADDRESS 1735 Hayford ave.

Important. See instructions on back.

Spec.—6-9-19—H. F. Co.—1000 Bks.

D. 51364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51364

CERTIFICATE OF DEATH.

15 - 79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3301 Gwynn Oak Ave. ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia Frances Mentzel

(a) RESIDENCE. No. 3301 Gwynn Oak Ave. ST., 28 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? 79 yrs. 4 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Mentzel

6 DATE OF BIRTH (month, day, and year) October-8-1841.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James F. Frazier

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rachel A. Sheppard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Mr. Jas. L. Thomas, (Son)
(Address) 3301 Gwynn Oak Av.

15 Filed Robert P. Harrison, Registrar
MAR 1 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1921, to Feb. 28, 1921, that I last saw h.e alive on Feb. 28, 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema and congestion

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Heart-weakness - dilatation

(duration) 3 or 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. T. Shemwell, M. D.

1921 (Address) 2226 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Mar-2-21 19

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH in plain terms, without abbreviations. See back of certificates. TION is very important.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Myocarditis

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51365 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51365

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH Woman's Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Lafayette & Johns ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Priscilla Griffith

(Residence in Baltimore: No. 1071 W Fayette St.; 87 yrs. ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, about ....., 1834.
(Month) (Day) (Year)

7-AGE, 87 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edward Griffith?

11-BIRTHPLACE OF FATHER (State or Country), U S A.

12-MAIDEN NAME OF MOTHER Evelina More Griffith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Julia E. Whitcher (Owner)

(Address)..... 1934 Linden Ave.

15-

Robert P. Harrison,

Filed....., 191.....

Registrar.

APR 1-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 28th 1921, 191...
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1921, to Feb 28 1921, that I saw h.r alive on ..... 1921, and that death occurred, on the date stated above, at 5.05 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneu.

..... (Duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Old age, Emphysema.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank H Bortheimer M. D.

Feb 28..., 1921. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 1 W. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1071 W Fayette.

Former or usual residence 1071 W. Fayette

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, May 2, 1921

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.51366 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51366

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 835 Wellington ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie B. Boyer

(Residence in Baltimore: No. 835 Wellington St.: 67y yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, Feb 15, 1830 (Month) (Day) (Year)

7-AGE 91 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Nicholas Statesbury

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER, Mary Brewer

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A Nelson

(Address) 835 Wellington

15-

Filed ..... 1921 Robert P. Harrison, Registrar.

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1st, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 10 1921, to Mar 1 1921, that I saw h[illegible] alive on Mar 1 1921, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary), Myocarditis & age indefinite (Duration) yrs. mos. ds.

(Signed) A Rheuark M. D.

Mar 1, 1921 (Address) 865 W 36 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery DATE OF BURIAL, Mar 3, 1921.

20-UNDERTAKER A. J. Marshall ADDRESS 2339 Eutaw

MAR 1 - 1921

important. See instructions on back of certificate.

D51367 HEALTH DEPARTMENT—CITY OF BALTIMORE D51367

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 931 Somerset St. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wooden

(Residence in Baltimore: No. 931 Somerset St. Life St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, Feb 28 1921
(Month) (Day) (Year)

7-AGE, yrs. mos. 1 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto No

PARENTS.

10-NAME OF FATHER, Steven M. Wooden

11-BIRTHPLACE OF FATHER (State or Country), Balto No

12-MAIDEN NAME OF MOTHER Anetta A. Walker

13-BIRTHPLACE OF MOTHER (State or Country), Balto No

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Steven M. Wooden

(Address) 931 Somerset St

15- Filed MAR 2 - 1921 Burial Permit Issued Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. K. Gundry M. D.
(Coroner.)

3-1-, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Cross Cemetery — DATE OF BURIAL, March 2, 1921

20-UNDERTAKER Henry Storck Sons — ADDRESS 1301 E Eager St

Cause of death must be stated in such terms as will be understood by the public generally. Indefinite terms, such as "Disease," "Debility," "Old Age," "Accident," "Unknown," etc., are not sufficient. Be sure to state the disease causing death, or, in deaths from violent causes, state (1) means of injury; and (2) whether accidental, suicidal, or homicidal. Be sure to answer all questions. Omissions cause unnecessary delay. Please write plainly with pen and ink. Punctuation and capitals are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51368

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51368

STILLBIRTH NO. 1054

CERTIFICATE OF DEATH.

REGISTERED NO. C 157

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Zuie Mc Cullah

(Residence in Baltimore: No. 2560 St.; 0 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): —

6-DATE OF BIRTH: March (Month) 1 (Day), 1921 (Year)

7-AGE: 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 3 hrs. or — min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country): md

PARENTS.

10-NAME OF FATHER: Mitchell Zuie

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Julia Weinstein

13-BIRTHPLACE OF MOTHER (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hebrew Hosp

(Address)

15- MAR 2 - 1921 Filed, 191... SOMER & KRAUTH Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 1, 1921, that I saw h— alive on March 1, 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) J Rosenberg M. D.

March 1, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 3-7..., 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

important. See instructions on back of Certificate

051369

HEALTH DEPARTMENT—CITY OF BALTIMORE

051369

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1704 E. Eager St. 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Libby Goldberg.

(Residence in Baltimore: No. 1704 E. Eager.

35

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White.	Married

6-DATE OF BIRTH. Unknown — (Month) (Day), 1857 (Year)

7-AGE. 64 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Tailor
(b) General nature of industry, business, or establishment in which employed (or employer). Self

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Baltimore

15-Filed MAR 2 - 1921, 191.... ROBERT I KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) B. K. Lewis M. D.
(Coroner)

....., 191... (Address) 1411 E. Balt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mehren Lauthen Cem. DATE OF BURIAL, 3-7, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Balt St

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51370 HEALTH DEPARTMENT—CITY OF BALTIMORE. D51370

CERTIFICATE OF DEATH.

74

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2345 McElderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Franklin Roeder

(a) RESIDENCE. NO. 2345 McElderry ST., WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hallethorpe
(State or country) Md

PARENTS

10 NAME OF FATHER Charles B Roeder

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Nebra B. Van Horn

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Charles B Roeder
(Address) 2345 McElderry St

15 MAR 2 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1921, to March 1, 1921, that I last saw him alive on March 1, 1921, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Dyspnoea

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William J Schmitz, M. D.

March 1921 (Address) 701 N Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	March 3 1921

20 UNDERTAKER Jos B Cook & Bro

ADDRESS 1003 W Baltimore St

TION is very important. See instructions on back of certificate.

S[illegible]—6-9-19—H. P. Co.—1000 Blks.

D51371 HEALTH DEPARTMENT—CITY OF BALTIMORE D51371

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: [illegible] WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Larkins

(a) RESIDENCE. NO. Della 2nd ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Toby

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Dora Larkins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant (Address)

MAR 2 - 1921

15 Filed ....., 19 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18 19 21

17 I HEREBY CERTIFY, That I attended deceased from February 19 19 21, to February 18 19 21, that I last saw h[illegible] alive on February 18, 19 21, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Marasmus (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. Pleyer, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	MAR 1 1921
20 UNDERTAKER	ADDRESS
Commissioner Health,	

Per. Wm. E. WOODALL

TION is very important. See instructions on back

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enteritis

D51372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51372

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 923 Bevan St. St.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Fannon.

(Residence in Baltimore: No. 923 Bevan St.

St.; 43 yrs., 4 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH,

October 16th. 1877, (Month) (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
43 yrs. 4 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Hack driver.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas Fannon.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Catherine.-------

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Fannon. (wife)

(Address) 923 Bevan St.

15- FILED MAR 2 - 1921 191... ROBERT I. KRAUTH Registrar. Racial Form: Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 28th. 1921. (Month) (Day) , 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

March 1, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Brooklyn | DATE OF BURIAL, March 4 1921

20-UNDERTAKER [illegible] | ADDRESS [illegible] Block S 626 E Northern

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HALL

951373 HEALTH DEPARTMENT—CITY OF BALTIMORE 951373

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Little Pine St ST.: 17 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Hall

(a) RESIDENCE. No. 924 Little Pine St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) June 27th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Austin Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie Tapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Lizzie Tapp (Address) 924 Little Pine St

15 Filed MAR 2 - 1921 19 ROBERT B. LAWTON Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 19 21

17 I HEREBY CERTIFY, That I attended deceased from Feb 28th 19 21, to March 1st 19 21, that I last saw h... alive on Feb 28th 19 21, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enterocolitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Status Collapse

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. J. Frantz M. D.

3-1 19 21 (Address) 701 Mt. Vernon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	March 6 1921
20 UNDERTAKER	ADDRESS
David Earlam	Cars

Spec.—6-9-19—H. P. Co.—1000 Bks.

Koch

D 51374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51374

CERTIFICATE OF DEATH.

8-091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 Shaw St ST.: 23 WARD)

2-FULL NAME Dorothy Koch

(a) RESIDENCE. No. 1030 Shaw St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Marie Rothe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John H. Koch

(Address) 1030 Shaw St

15 Filed MAR 2 - 1921 ROBERT B KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to Mar 1, 1921, that I last saw h[illegible] alive on Mar 1, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

2 (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? No Clinically

What test confirmed diagnosis?

(Signed) H. R. Campbell, M. D.

Mar 2, 1921 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 2 1921

20 UNDERTAKER Mrs. E. E. Hunt ADDRESS [illegible]

TION is very important. See instructions on back of certificate.

D 57375 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57375

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1037 N. Carey ST. 16 79 WARD) REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Morris

(Residence in Baltimore: No. 1037 N. Carey St. 57 St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH. November, 1870
(Month) (Day) (Year)

7-AGE. 51 yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country) Maryland

PARENTS.

10-NAME OF FATHER. Wm. Robinson

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Morris

(Address) 1412 Mosher St

15- Filed MAR 2 - 1921 191..... ROBERT J. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart dis.

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) and Influenza

(Duration) yrs. mos. ds.

(Signed) J. A. D. Hennessy M. D.
(Coroner.)

Feb. 28 1921 (Address) 2801 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn — DATE OF BURIAL. Mch 2 1921

20-UNDERTAKER John H. Toadvine — ADDRESS 142 W. Lee St

Fill out all items. Be accurate and complete. Use ink. Please write plainly. Do not abbreviate. Be sure to answer every question. If any question does not apply write "none" or "not applicable." Where information is not known, write "unknown." Do not leave any blanks. All items are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51376

91

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 John ST.: 11 WARD)

2-FULL NAME Mary Tilghman Hollyday Stewart,

(a) RESIDENCE. NO. 1204 John ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed or divorced~~ ~~HUSBAND~~ (or WIFE of) James Heighe Stewart

6 DATE OF BIRTH (month, day, and year) Feb. 12, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	No	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ none

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 037

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) near Hagerstown Washington Co. Md.

PARENTS

10 NAME OF FATHER William Hollyday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington Co. Md.

12 MAIDEN NAME OF MOTHER Louise Lamar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Allegany Co. Md.

14 Informant Lamar Hollyday Stewart

(Address) 1311 John St.

15 MAR 2 - 1921 BOARD OF HEALTH

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1921, to March 1, 1921, that I last saw h Er alive on March 1 1921, and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis —

(duration) Many yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia —

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical examination

(Signed) Clarence Neal, M. D.

, 19 (Address) 132 Park Ave. Balto —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Mar 3rd 1921

20 UNDERTAKER: Henry A. Jenkins Sons Co — ADDRESS: McCulloh & Eutaw

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51377

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 N. Madeira ST.: 7 WARD)

2-FULL NAME Carrie M. Bachstein

(a) RESIDENCE. NO. 803 N. Madeira ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 4 mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14 - 94

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Wm F. Bachstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Borrman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm F. Bachstein
(Address) 803 N. Madeira

15 FILED MAR 2 - 1921 ROBERT B. [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28/21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1921, to Feb 28, 1921, that I last saw h[illegible] alive on Feb 28, 1921, and that death occurred, on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Findings

(Signed) J. W. Bunzel, M. D.

(Address) 20 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	3/3/21
20 UNDERTAKER Philip Herwig	ADDRESS 3016 Arlington

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Anzalone

D51378

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51378

CERTIFICATE OF DEATH.

8-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 East st. St.: 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Giuseppina Anzalone

(a) RESIDENCE. No. 323 East St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 30-1920

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	1	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Gaetano Anzalone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Cynzella Fantuzzello

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Gaetano Anzalone

(Address) 323 East st.

15 MAR 2 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 19 21

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1921, to Mar 2, 19 21.

that I last saw her alive on Mar 1, 19 21.

and that death occurred, on the date stated above, at 2 1/4 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Isaac L Ditchett, M. D.

Mar 2 19 21 (Address) 1034 Mercedary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent Cemetary

DATE OF BURIAL 3/2/21 19

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Hanford Ave

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

051379 HEALTH DEPARTMENT—CITY OF BALTIMORE 051379

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 667 Columbia Av St.; 22 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Adams no. 1.

(Residence in Baltimore: No. 667 Columbia Av St. ..... yrs., ... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male ~~Female~~

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, March (Month) 1 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 5 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Joseph G. Adams

11-BIRTHPLACE OF FATHER (State or Country), St. Mary Co. Md

12-MAIDEN NAME OF MOTHER Margaret Larkin

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph G. Adams

(Address) 667 Columbia ave

15- Filed MAR 2 - 1921, 191... ROBERT J. KRAUTER Registrar.

Corrected 3/10/21
Dr. J. M. Shlesowsky

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 1 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1921, to Mar 1 1921, that I saw him alive on Mar 1 1921, and that death occurred, on the date stated above, at 10-20 P.m.

The CAUSE OF DEATH* was as follows:

Premature Labor
(4½ months)
(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Shlesowsky M. D.

3/2, 1921. (Address) 638 Columbia Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 667 Columbia Av

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, March 2, 1921

20-UNDERTAKER, James Dignan & Son — ADDRESS 1000 S. Paca St

Important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D51380 HEALTH DEPARTMENT—CITY OF BALTIMORE D51380

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 667 Columbia Ave ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Adams No. 2

(Residence in Baltimore: No. 667 Columbia Ave St.; ..... yrs., ... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	

6-DATE OF BIRTH, March (Month) 1 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Joseph G. Adams

11-BIRTHPLACE OF FATHER (State or Country), St Mary Co. Md

12-MAIDEN NAME OF MOTHER Margaret Larkin

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph G. Adams

(Address) 667 Columbia ave

15- Filed MAR 2 - 1921 ROBERT J KRAUTER BUREAU OF VITAL STATISTICS

important. See instructions on back of Certificate

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 1 st (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from Mar 1 1921, to Mar 1 1921, that I saw h m alive on March 1 1921, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Premature Labor
(4½ month.)
..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Mar 2, 1921. (Address) 667 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 667 Columbia Ave

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, March 2, 1921.

20-UNDERTAKER James D. Quan & Son

ADDRESS 1000 S. Pacast

Spec.—8-24-14—M. & T.—2000 Blks.

D 51381

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51381

CERTIFICATE OF DEATH.

REGISTERED NO. C 912

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 - 22 1/2 ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maurice B. Spriggs.

(Residence in Baltimore: No. 406 - 22 1/2 St.; — yrs., 7 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Negro.	single.

6-DATE OF BIRTH, July (Month) 7 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
— yrs. 7 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Born in Baltimore Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Major McSpriggs.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Bertha E. Shorte

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Berthia B. Spriggs

(Address) 406 22½ St

15- ROBERT J. KRAUTER

Filed....., 191... Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 25 1921, to Feby 28 1921, that I saw him alive on Feby 28, 1921, and that death occurred, on the date stated above, at 9.20 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration)....yrs....mos....ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) Haught Forsythe, M. D.

Mch 1, 1921. (Address) 424 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, March 2., 1921

20-UNDERTAKER Mrs Robert A Elliott — ADDRESS 1725 Ashland

Conrad Marr.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51382 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D51382

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 Paul ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Konrad Marr

(a) RESIDENCE. NO. 311 Paul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of Elizabeth Marr

6 DATE OF BIRTH (month, day, and year) May 11 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Johann Marr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rühr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Marr

(Address) 311 Paul St

15 Filed ..... 19..... ROBERT J. KRAUTER Registrar

MAR 2 - 1921 Burial Permit Otord

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to March 1, 1921, that I last saw h.. alive on March 1, 1921, and that death occurred, on the date stated above, at 11 30 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E E Marr M. D.

March 2 1921 (Address) 827 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mar 4 1921
20 UNDERTAKER	ADDRESS
W M Routson	238 N Grove

CAUTION is very important. See instructions on back of certificate.

Form.—6-9-19—H. P. Co.—1000 Blks.

D51383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51383

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 George ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ema Comer Bonds-

(a) RESIDENCE. NO. 613 George ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bonds.

6 DATE OF BIRTH (month, day, and year) July 28, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid. 070

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel Maid.

(c) Name of employer Hotel Kernan Baltimore.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER George W Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredericksburg Md

12 MAIDEN NAME OF MOTHER Rosie Burkitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Rosie Fisher.
(Address) 613 George St

15 MAR 2 - 1921 ROBERT E KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1921, to Feb 28, 1921, that I last saw h... alive on Feb 27, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

Feb 28, 1921 (Address) 1209 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mar 3 1921
20 UNDERTAKER	ADDRESS
Ernest D Hundley	Md Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51384 HEALTH DEPARTMENT—CITY OF BALTIMORE D51384

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 608 Hanover St. ST.: 5 WARD. REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Jennie Holland

(a) RESIDENCE. NO. 608 Hanover ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of J B Holland

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant James H Dennis

(Address) 1303 Presstman St

15 Filed ..... 19 .....

MAR 2 - 1921

ROBERT E CRAWFORD

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/2/21 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 19 21 to March 2/21, 19..., that I last saw her alive on March 2/21, 19..., and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) as above.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert Levy M.D.

3/2/21 19 (Address) 1207 E. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Portbello Md	Mar 6 1921

20 UNDERTAKER ADDRESS

James H Dennis 1303 Presstman St

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51385 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51385

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 161 N. Curley ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Kamka

(a) RESIDENCE. No. 161 N. Curley ST., 6 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Kamka

6 DATE OF BIRTH (month, day, and year) Aug 7 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General natore of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mrs. Emma Kamka
(Address) 161 N. Curley St.

15 Filed 3-2-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Mar 1- 21, that I last saw h[illegible] alive on Mar 1- 1921, and that death occurred, on the date stated above, at 3 P- m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(doration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Geo. Luther Cadee M. D.

(Address) 443 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	3-4 1921
20 UNDERTAKER J. J. Moran	ADDRESS 3000 E Baltimore

TION is very important. See instructions

R 2-1921

Spec.—8-24-14—M. & T.—2000 Blks.

D. 51386

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51386

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH Hebrew Hospital

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 619 Bartlett ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. William A. Harp

(Residence in Baltimore: No. 619 Bartlett ave St.; 62 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug. (Month) 6 (Day), 1858 (Year)

7-AGE, 62 yrs. 6 mos. 22 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm H. Harp

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Sarah J. Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Harp

(Address) 619 Bartlett ave

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

MAR 2 - 1921 Burial Permit Clerk

CAUSE OF DEATH to be plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 27 1921, to Mch 1 1921, that I saw h[illegible] alive on Mch 1 1921, and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

Pulmonary edema

..... (Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary edema

..... (Duration) ..... yrs. ..... mos. 1/2 ds.

(Signed) Louis Jacobs M. D.

....., 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... moe. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, March 4., 1921.

20-UNDERTAKER Pinkler & Pinkler

ADDRESS 1739 Eager st

Spec.—6-9-19—H. P. Co.—1000 Bks.

051387

HEALTH DEPARTMENT—CITY OF BALTIMORE

051387

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 S. Carlton ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bridget D. Dogarty

(a) RESIDENCE. NO. 110 S Carlton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Aug 2nd 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Tyrrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Fogarty (Address) 110 S Carlton St

15 Filed MAR 3 - 1921 ROBERT I. FRANKE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1921

17 I HEREBY CERTIFY, That I attended deceased from February 28, 1921, to March 2, 1921, that I last saw her alive on March 1, 1921, and that death occurred, on the date stated above, at 4.15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Chronic nephritis

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) —— (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Edmund J. Feeney, M. D.

3/2, 1921 (Address) 710 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	March 4 1921

20 UNDERTAKER John J. Fields ADDRESS 1200 W Lombard

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51388 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51388

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Smith

(a) RESIDENCE. No. Irvington Virginia ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) February 27, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wallace St Clair Smith

11 BIRTHPLACE OF FATHER (city or town) Irvington
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Norma Louise Russell

13 BIRTHPLACE OF MOTHER (city or town) Irvington
(State or country) Virginia

14 Informant (Father) Wallace St Clair Smith
(Address) Irvington Virginia

15 Filed MAR 2-1921 Robert P. Harris
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from February 27, 1921, to March 2nd, 1921, that I last saw him alive on March 2nd, 1921, and that death occurred, on the date stated above, at 11:45 A.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

— (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ?

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) J. Morris Reese, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Irvington Va	Mar 4 21
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W Lombard

TION is very important. See instructions on back of certificates.

D. 51389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51389

CERTIFICATE OF DEATH.

64

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Quinlan

(Residence in Baltimore: No. Alla & Maple aves Anden St.; yrs. live mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, December 9, 1864. (Month) (Day) (Year)

7-AGE, Years 57 Months Days. If LESS than 1 day, Hrs. or Min.? With said

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Capt. of Mariners

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Quinlan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Emma

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Quinlan

(Address) Alla & Maple aves

15- Filed ..... 191.. Robert P. Harrison, Burial Permit Clerk. Registrar.

APR 2 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28, 1914. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Cirrhosis Pancreas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] (Coroner.) M. D.

April 29, 1914. (Address) 1657 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	May 1, 1914
20-UNDERTAKER	ADDRESS
Randall Hagerstown	27 Seventh

IMPORTANT. See instructions on back of certificate.

Spec. 8-2-19 H. P. Co. 1000 Blks.

D. 51390 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51390

CERTIFICATE OF DEATH. 9

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 26 WARD)

2-FULL NAME Ferdinand Rini

(a) RESIDENCE. NO. 620 Clinton ~~St~~ ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	9	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Ferdinand Rini

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Plotner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Ferdinad Rini
(Address) 620 Clinton Street

15 Filed Mar 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 1, 1921, that I last saw him alive on March 1, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cultures positive.

(Signed) B MacLennan M. D.

3/7 1921 (Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 3/2 1921

20 UNDERTAKER William Cook — ADDRESS 502 E Natl

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51391 HEALTH DEPARTMENT—CITY OF BALTIMORE D51391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Lafayette & Linden ST.; 12 WARD) 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elana Gisinger

(Residence in Baltimore: No. 339 W 21st St. St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 4, 1866. (Month) (Day) (Year)

7-AGE, 54 yrs. 9 mos. 26 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, George E. Shuttle

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Elizabeth Hoover

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel L. Gisinger

(Address) 339 W. 21st Street

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

MAR 2 - 1921 Burial Permit Clerk.

CAUSE OF DEATH. Information on back of certificate important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 4 1921, to March 1 1921, that I saw h[er] alive on March 1 1921, and that death occurred, on the date stated above, at 9.05 A m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart, pulmonary edema

..... (Duration) ..... yrs. ..... mos. 31 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

fibrillation (Duration) 15 yrs. ..... mos. ..... ds.

(Signed) Frank DeWalten Stein M. D.

March 2, 1921. (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 50 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Druid Ridge	March 5, 1921.
20-UNDERTAKER	ADDRESS
William Cook	502 E. North Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

D. 51392 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51392

CERTIFICATE OF DEATH. 1279

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 E. 20th St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Alexana Bucher

(a) RESIDENCE. No. 414 E 20th St., 12 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo W. Bucher

6 DATE OF BIRTH (month, day, and year) Mar 18-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): Wife

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Geo M. Bucher 1815 Madison Ave

15 Filed MAR 2 - 1921 Robert P. Harrison Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 18th, 1921, to Feby 28, 1921, that I last saw h[illegible] alive on Feby 28, 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans
had a fall today — never recovered
from shock* (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hugh Forsyth, M. D.

, 19 (Address) 424 E. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Waverley	Mar 3 1921

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Gwynn

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51393 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 N. Mt. St.; 16 8-07 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes L. Rice

(Residence in Baltimore: No. 1025 N. Mount St.; .....yrs., 2 mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	

6-DATE OF BIRTH, Dec. 18, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. .....ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Rice

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Mair

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Rice

(Address) 1025 N. Mount St.

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

AR 2-1921 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 2nd, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 28 1921, to Mch 2 1921, that I saw her alive on Mch 1st 1921, and that death occurred, on the date stated above. at 7a, m.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

..... (Duration).....yrs.....mos. 2 wks. .....ds.

CONTRIBUTORY (Secondary) Convulsions

..... (Duration).....yrs.....mos. 3 .....ds.

(Signed) Chas. H. Bartlett M. D.

Mch. 2, 1921. (Address) 1100 Linden Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross | DATE OF BURIAL, Mar 3 1921

20-UNDERTAKER H. C. Wiedefeld | ADDRESS 914 Greenmount Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51394 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51394

CERTIFICATE OF DEATH. 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2060 Eastern ave ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kasila Silvistowicz

(a) RESIDENCE. NO. 2060 Eastern ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Silvistowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia Stepor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Charles Silvistowicz 2060 Eastern ave

15 Filed ....., 19..... Registrar

CAUSE OF DEATH in plain terms, so that a ... TION is very important. See instructions on ... s on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1924, to March 1, 1924, that I last saw h.. alive on March 1, 1924, and that death occurred, on the date stated above, at 5 0 m.

The CAUSE OF DEATH* was as follows:

gastro intents

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Wanbaugh, M. D.

March 1, 19 24 (Address) # 2 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 3 1921

20 UNDERTAKER John McArthur ADDRESS 1803 Bank St

MAR 2—1921 Burial Permit Clerk

Form — 6-9-19 — H. P. Co. — 1000 Blks.

20.51395 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51395

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2027 Fleet St ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME walter Apson Jr

(a) RESIDENCE. No. 2027 Fleet St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Apson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dora Kolodziejska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Walter Apson
(Address) 2027 Fleet St

15 Filed MAR 2 - 1921 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/25, 1921, to 3/1, 1921, that I last saw h[illegible] alive on 3/1, 1921, and that death occurred, on the date stated above, at 945 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia & Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy & Symptoms

(Signed) John B Hubbert, M. D.

3/2 1921 (Address) 1623 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 3 '21
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

20.51396 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 425 E. Fort Ave. St.: 24 WARD) 79 REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Hemerich.

(Residence in Baltimore: No. 1400 Woodall St. St.: 45 yrs., 7 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Married.

6-DATE OF BIRTH. July 4th. 1875., 1 (Month) (Day) (Year)

7-AGE, 45 yrs. 7 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Conrad Schaefer.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Mary N?Geis.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Hemerich. (husband)

(Address) 1400 Woodall St.

15- Filed MAR 3 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 27th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto E. Fernhard M. D. (Coroner.)

Feb. 27., 1921 (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Mar. 3, 1921
20-UNDERTAKER E. J. Fanning & Son	ADDRESS Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51397 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51397

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 508 S. Hanover ST. 27 WARD)

2-FULL NAME Miriam Eliason

(a) RESIDENCE. No. 508 S Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bonch Eliason

6 DATE OF BIRTH (month, day, and year) ——— 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Moses

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ethel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Bonch Eliason
(Address) 508 S Hanover

15 Filed MAR 2 — 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH IN plain words. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1917, to March 1, 1921, that I last saw her alive on March 1, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Erysipelas, Septicemia (Cause probably self scratched)

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic Interstitial Nephritis (duration) 15 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May, 1920

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Davis Franklin, M. D.

3/2, 19 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd	Mar 2. 1921
20 UNDERTAKER Max Levinson	ADDRESS 1127 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D.51398

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51398

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 79

CITY OF BALTIMORE: (No. Home for the Aged of the H 20 ST. ~~Avenue~~)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Susan E. Maddox

(Residence in Baltimore: No. S.W. Cor Fulton Ave & Franklin St.; ..... yrs., Lifetime mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec 25, 1843
(Month) (Day) (Year)

7-AGE, 77 yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): housewife

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jos. Carman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Lucretia Auld.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Etta Cuddy Supt.

(Address) 400 N. Fulton Ave

15-

Filed Mar 2 1921 Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 1919, to Mch 1 1921, that I saw h^er alive on Febry 22. 1921, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows: See back

Valvular heart trouble

(Mitral) (Duration) 2 yrs. 4 mos. 5 ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(Duration) 3 yrs. 4 mos. 4 ds.

(Signed) George E. Shannon M. D.

Mar. 2, 1921 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Mar. 3., 1921

20-UNDERTAKER George J. Smith — ADDRESS 1000 N Fayette st

MAR 2 - 1921

CAUSE OF DEATH. Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51399 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51399

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4902 Park Heights ave St. 15 WARD) REGISTERED No. C 579

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas S.R. Browning

(Residence in Baltimore: No. 1347 N. Gilmore St. St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 5th (Month) (Day), 1865 (Year)

7-AGE, 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer) Watchman

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm M. Browning

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ellen Laurence

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. J. Smith

(Address) 1000 W. Fayette St

15-

Filed MAR 2-1921, 191 Robert P. Harrison, Registrar.

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1st (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased ~~from~~ during last fifteen minutes of life 191, 18 191, that I saw h~~im~~ alive on March 1st 1921, and that death occurred, on the date stated above, at 10.45 m.

The CAUSE OF DEATH* was as follows:

(Organic heart disease)
Chronic Myocarditis
unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis
unknown (Duration) yrs. mos. ds.

(Signed) E.B. Evans M. D.

3-2, 191.. (Address) 5016 Park Heights ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park. DATE OF BURIAL, March 4, 1921

20-UNDERTAKER George J Smith ADDRESS 1000 W Fayette

CAUSE OF DEATH to be plainly written. Every question must be answered if possible. Omissions will cause delay. Words "unknown" or "none" are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1009 Blks.

20.39400

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51400

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 11 WARD)

2-FULL NAME Grace Smiley.

(a) RESIDENCE. NO. 1208 madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 27-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER George Smiley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Thelma Wilson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Hospital
(Address)

15 Filed MAR 2-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1921, to March 2, 1921, that I last saw h[er] alive on March 2, 1921, and that death occurred, on the date stated above, at 6 55 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X ray

(Signed) L W Davison, M. D.

, 19 (Address) 1 W Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: March 3- 1921

20 UNDERTAKER: William Cook — ADDRESS: 503 E. Madison Ave

CAUSE OF DEATH on place for certificates. See instructions on back of certificates. TION is very important.

20.51401 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51401

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6 W. 20th St. ST.: 17 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kathleen Peregoy

(Residence in Baltimore: No. 6 W 20th St) Single, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	W	

6-DATE OF BIRTH, April (Month) 22 (Day), 1920 (Year)

7-AGE, ...yrs. 10 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Raymond Peregoy

11-BIRTHPLACE OF FATHER (State or Country). Balt.

12-MAIDEN NAME OF MOTHER Hadwig Hillo

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Peregoy

(Address) 6 W 20th St

15-

Filed ....., 191.... Robert F. Hannigan, Registrar.

MAR 2-1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner)

1921 (Address) 528 2 Rolandave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Druid Ridge — DATE OF BURIAL, Mch 3, 19 2

20-UNDERTAKER Wm Cook — ADDRESS 118 N

CAUSE OF DEATH to be filled in plain terms; important. See instructions on back of certificate.

Form. 6-9-19—H. P. Co.—1000 Hka.

D51402 HEALTH DEPARTMENT—CITY OF BALTIMORE D51402

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 W Hamburg St. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Maris

(a) RESIDENCE. No. 122 W Hamburg - WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? yrs. mos. ds.

life time

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March. 2. 21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE - ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Gelbert Maris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland -

12 MAIDEN NAME OF MOTHER Lenka Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland -

14 Informant (Address) Gelbert Maris - 122 W Hamburg

15 Filed MAR 3 - 1921 ROBERT E LAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1921

17 I HEREBY CERTIFY, That I attended deceased from March x 1921 to March 2. 1921. that I last saw him alive on March 2. 1921. and that death occurred, on the date stated above, at 1-15 p m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) one hour -

CONTRIBUTORY (Secondary) Premature birth

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of -

Was there an autopsy? No -

What test confirmed diagnosis? -

(Signed) M C Friedinger M.D.

19 21 (Address) 682 Col-Ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Mar 3 1921
20 UNDERTAKER	ADDRESS
Knell & Son	1724 N Bradt St

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

D51403

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 51403

REGISTERED NO. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1414 Decatur ST.: 24 WARD)

2 FULL NAME Gloria Kaneen

(Residence in Baltimore: No. 1414 Decatur St. St.: yrs. 8 mos. ds.)

Exact statement of OCCUPATION may be properly classified. Every item of information should be entered; if unknown, supply approximate. N. B.—Every item of information should be entered; if unknown, supply approximate. Exact statement of OCCUPATION may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March 14, 1919 (Month) (Day) (Year)

7 AGE: 1 yrs. 11 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Kingston Jamaica B.W.I.

PARENTS

10 NAME OF FATHER: Harry W Hansen

11 BIRTHPLACE OF FATHER (State or country): Denmark

12 MAIDEN NAME OF MOTHER: Julia Sabio

13 BIRTHPLACE OF MOTHER (State or country): Jamaica B.W.I.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry W. Hansen

(Address) 1414 Decatur st

15. Filed MAR 3 - 1921 ROBT. J. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 1, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1921, to March 1 1921.

that I saw h[illegible] alive on Feb 28, 1921.

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Thos F Stevens M. D.

March 2, 1921 (Address) 2366 Eastford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted. If not at place of death?

Former or usual residence: Jamaica B W I

19 PLACE OF BURIAL OR REMOVAL: Holy Cross a.a.c.o

DATE OF BURIAL: March 3d 1921

20 UNDERTAKER: A. Jones

ADDRESS: 207 S. Bruckn[illegible]

Stec.—6-9-19—H. P. Co.—1000 Bks.

D51404 HEALTH DEPARTMENT—CITY OF BALTIMORE D51404

D51404

CERTIFICATE OF DEATH.

REGISTERED No. 15 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 N. Fulton Ave. ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Maude Rodgers

(a) RESIDENCE. No. 2116 N. Fulton Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21" 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County

(State or country) Md.

PARENTS

10 NAME OF FATHER John S. Rodgers

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret A. Fryfogle

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co.

(State or country) Md.

14 Informant Mrs E.N. Frey

(Address) 2116 N. Fulton Ave.

15 MAR 3 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 1" 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 5 1920, to March 1 1921,

that I last saw her alive on Feb 28 1921,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of dorsal Vertebra

(duration) 2 yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. — ds.

18 Where was disease contracted, if not at place of death? 2116 N Fulton ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Burch Joyce, M. D.

19 (Address) 1800 W North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem. Roslyn	March 3 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Gay St.

TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51405 HEALTH DEPARTMENT—CITY OF BALTIMORE D51405

CERTIFICATE OF DEATH. 79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 W. Fayette St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia M. Schley

(a) RESIDENCE. NO. 1613 W. Fayette St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Allen F. Schley

6 DATE OF BIRTH (month, day, and year) Apr. 8th 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER John Sturgeon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant George V. Schley (Address) 522 N. Monroe St.

15 Filed MAR 3 - 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to March 1, 1921, that I last saw her alive on Feb 28, 1921, and that death occurred, on the date stated above, at 4.30A. m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis and Chronic Myocarditis

(duration) Ouer 2 mos. — ds.

CONTRIBUTORY (Secondary) None (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ex of Heart & Blood vessels

(Signed) Henry C. Ohler M. D.

March 1 1921 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	March 3rd 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N. Bolton Street.

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51406

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2709 Roslyn Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willard Leonard

(a) RESIDENCE. No. 2709 Roslyn ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Leonard

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Official

(b) General nature of industry, business, or establishment in which employed (or employer) Fidelity & Trust Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER John Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Berry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary A Leonard

(Address) 2709 Roslyn Ave

15 Filed MAR 3 - 1921 19 [illegible] Registrar

Burial Permit Given

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1921, to March 1, 1921, that I last saw him alive on March 1, 1921, and that death occurred, on the date stated above, at 9:45 A m.

The CAUSE OF DEATH* was as follows:

Pyelo-Nephritis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edgar P. Saudrock M. D.

19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Mar 4 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 N Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51407 HEALTH DEPARTMENT—CITY OF BALTIMORE D51407

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2339 Eastern Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jagielski

(a) RESIDENCE. NO. 2339 Eastern Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Jagielski

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Michael Jagielski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Frances Melanek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ida Jagielski
(Address) 2339 Eastern ave

15 Filed ....., 19.... [illegible] Registrar
MAR 3 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1921, to March 1, 1921, that I last saw [illegible] alive on March 1, 1921, and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) ....yrs. 6 mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Gassert M. D.

(Address) 801 N Kenwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Mar 4 1921
UNDERTAKER William Gassert	ADDRESS 1018 East

CAUSE OF DEATH. See instructions on back of certificate. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51408

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51408

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1541 E. Clinton ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Guth.

(a) RESIDENCE. No. 1541 E. Clinton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(h) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Phillip Guth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Pearl Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Phillip Guth

(Address) 1541 E. Clinton St

15 Filed MAR 3 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1921, to Mar. 2, 1921, that I last saw him alive on Feb 20, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) x yrs. x mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia (duration) x yrs. x mos. 7 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? same

(Signed) Jas. L. Tuey, M. D.

Mch. 1921 (Address) 2455 30 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Mar 4 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Flat St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D57409 HEALTH DEPARTMENT—CITY OF BALTIMORE D51409

CERTIFICATE OF DEATH.

170

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 W. Hamilton Ave. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie F. Weber

(a) RESIDENCE. No. 200 W. Hamilton Ave. ST., 27 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 20 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rost

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Claasen

(Address) #200 W. Hamilton Ave

15 MAR 3 - 1921 ROBERT J. KRAUTH Registrar

Burial Permit Oiled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 19 20, to Mar 2 d, 19 21,

that I last saw h alive on Mar 2 d, 19 21,

and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Interstitial Nephritis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 200 Hamilton Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 40 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Terra Hall Cem	March 5 19
20 UNDERTAKER	ADDRESS
Louis Heemann	22 S Broadway

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51410

61 X

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lauterback

(a) RESIDENCE. No. 4008 Edmondson Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe-fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 MAR 3 - 1921 ROBT. F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1921 to March 2, 1921 that I last saw h in alive on March 2, 1921 and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Epidemic meningitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Ulyocardial insufficiency (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Bacteriological proof.

(Signed) L. Stevenman, M. D.

3/3/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmal	Mar 5 192
20 UNDERTAKER W. M. Cook	ADDRESS 502 E North Ave

CAUSE OF DEATH: Important points to be covered in filling out this CERTIFICATE are given on back of certificate. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51411 HEALTH DEPARTMENT—CITY OF BALTIMORE D51411

CERTIFICATE OF DEATH. 54

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Front cor Hillsdale ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Clarkson Pace

(a) RESIDENCE. NO. Front cor Hillsdale ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND) of ~~(or WIFE)~~ of Mary E. Pace

6 DATE OF BIRTH (month, day, and year) Feb 10 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman 61

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jno Pace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Loudoun Co Va

12 MAIDEN NAME OF MOTHER Catherine Heydt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Loudoun Co Va

14 Informant Mary E. Pace

(Address) Fourth cor Hillsdale

15 Filed MAR 3 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1919, 19..., to Mar 1st 1921, that I last saw him alive on Mar 1st 1921, 19..., and that death occurred, on the date stated above, at 3 12 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Acute

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard Mummert, M. D.

, 19 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 3 1921

20 UNDERTAKER Robt S Lisle ADDRESS

CAUSE OF DEATH in plain words. Do not use abbreviations or technical terms. Consult physician if necessary. Any additional facts of importance in completing the medical history of the case should be given. INSTRUCTION is very important. See instructions on back of certificates.

D51412

Spec.—6-9-19—H. P. Co.—1000 Bks.

81 D51412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Sterling, St.: 6 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Kreisel

(a) RESIDENCE. No. 615 Sterling St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ (or) WIFE of John C Kreisel

6 DATE OF BIRTH (month, day, and year) March 21st 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER John Reutze

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME* OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Miss Sophie K Kreisel

(Address) 615 Sterling st

15 FILED MAR 3 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1921

17

I HEREBY CERTIFY, That I attended deceased from January 28th 1921, to March 1st 1921, that I last saw h... alive on January 28th 1921, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

Auricular Fibrillation (duration) yrs. mos. ds.

CONTRIBUTORY Cardiac Insufficiency (Secondary) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Lowe, M. D.

March 19 21 Address 1504 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Mar 4th 1921
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 Eden st

CAUSE OF DEATH must be stated plainly. Use no abbreviations or terms not generally understood. Do not state mode of dying, such as heart failure, asphyxia, or coma, but the disease or injury which caused it. Operations should be stated only when performed for some other disease than that which caused death. Violent deaths must be fully explained. Deaths from accident, suicide, or homicide must be reported to the Coroner before burial. Deaths from contagious diseases must be reported to the Health Department at once. Deaths from all other causes must be reported within 24 hours. See instructions on back of certificates.

Augustus Bradford

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51413

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51413

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Bradford

(a) RESIDENCE. NO. 221 E Preston St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Widower

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND~~ of
(or) ~~WIFE~~ of
Widow

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
About	80 Yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Augustus Bradford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Edna Kell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Belair Md

14 Informant Samuel W Bradford
(Address) Belair Md

15 Filed MAR 3 - 1921 ROBERT I GRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to March 2, 1921, that I last saw him alive on March 2, 1921, and that death occurred, on the date stated above, at 1.40 m.

The CAUSE OF DEATH* was as follows:

Cancer of liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cedema of lungs

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ~~Yes~~ Date of ~~March~~

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J W Porterfield, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	March 4 1921
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Sons Co	Orchard & Madison

CAUTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51414 HEALTH DEPARTMENT—CITY OF BALTIMORE D51414

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Gray

(a) RESIDENCE. NO. Forest Hill, Harford Co ST.; WARD. Forest Hill Harford Co.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Reuben Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County Md.

12 MAIDEN NAME OF MOTHER Mable Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford County Md

14 Informant Reuben Gray
(Address) Forest Hill Harford Md

15 Filed MAR 3 - 1921, 19 ROBERT J. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1921 to March 1, 1921, that I last saw him alive on March 1, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Brohawn, M. D.

(Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cattle Harford Co Md	3/4/21
20 UNDERTAKER J B Clyes	ADDRESS 1404 Mad

CAUSE OF DEATH. ... TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D-51415 ✓ D-51415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 E. Hoffman ST.: 8 WARD)

2-FULL NAME Harry L. Bruckerr

(a) RESIDENCE. NO. 2004 E. Hoffman ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Bruckerr

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER C. M. Barrickerr

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mary M. Barrickerr (Address) 2004 E. Hoffman St

15 MAR 3 - 1921 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1920, to March 2, 1921, that I last saw him alive on March 2, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency 7 ds.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Empyema (Pulmonary) 5 ds.

(duration) yrs. 3 mos.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Dec 1-1920

Was there an autopsy? No

What test confirmed diagnosis? Operation 12/1/20

(Signed) A. Reid Moullet, M. D.

, 19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 4 1921
20 UNDERTAKER Henry Lutz	ADDRESS 1007 N. Bond

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Para Influenza
in 1914 + never gotten
over the infection.
Probably T. B.

Form 6-9-19—H. P. Co.—1000 Blks.

D51416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51416

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 92

CITY OF BALTIMORE: (No. 1311 or North Ave. St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leopold Ehrlich

(a) RESIDENCE. No. 1311 or North Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Sarah Ehrlich

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Cigars 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savannah Ga

PARENTS

10 NAME OF FATHER Edward Ehrlich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rezdahlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herman Lowenberg
(Address) 2023 Park Heights Ave

15 Filed MAR 3 - 1921 ROBERT F. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1921, to Mar. 1, 1921, that I last saw him alive on Mar 1, 1921, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. Cleveland, M. D.

19 (Address) 1701 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Ham Lot	Mar 4th 1921
20 UNDERTAKER	ADDRESS
J. Adreon & Co.	16[illegible] Madison Ave

CAUSE OF DEATH to plain letters. Fill in all blanks with ink or typewriter. Physician's certificate is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51417 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51417

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 Nelkins av ST.; 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Hesselbacher

(a) RESIDENCE. No. 1815 Nelkins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 52 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Hesselbacher

6 DATE OF BIRTH (month, day, and year) Oct 14=1850

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Hesselbacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Carrie Hessler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Hesselbacher (Address) 1815 Nelkins av

15 Filed Robert P. Harrison, Registrar

MAR 3 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to March 2 1921, that I last saw him alive on mch 2, 1921, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Coloma of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) chronic interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? hematuria

(Signed) Walter A Cat, M. D.

33, 1924 (Address) 541 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 5th 1921

20 UNDERTAKER ADDRESS

H. D. Skippert 2416 Fredk av

CAUSE OF DEATH in plain terms, so that a TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51418

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51418

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 Central Ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J West

(Residence in Baltimore: No. 1206 Central Ave St.; 50 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Jan 15, 184.. (Month) (Day) (Year)

7-AGE, 76 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Horse
(b) General nature of industry, business, or establishment in which employed (or employer) Wife

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, John Kelly.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. West.

(Address) 206 N. Central ave

15-

Filed.....1921 Robert P. Harrison..... Registrar.

MAR 3 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 26 1921, to Mch 1 1921, that I saw her alive on Feb 28 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

(a) Broncho Pneumonia

..... (Duration).....yrs.....mos. 3 ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) E. Gill Hall M. D.

Mch 3, 1921 (Address) 1617 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, March 4, 1921

20-UNDERTAKER George J. Ruth — ADDRESS 735 Hanford ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D. 51419

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51419

CERTIFICATE OF DEATH.

6-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3900 Phila Ave. St.; 26 Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl V. Robinson

(Residence in Baltimore: No. Lefs 3900 Phila. Ave. St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Feb 2, 1919. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
1 yrs. 6 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Chas Robinson

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Ladie Baker.

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Robinson

(Address) 3900 Phila ave.

15- Robert P. Harrison,

Filed ..... 191.....

MAR 3 - 1921 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 28 1921, to March 2 1921, that I saw her alive on March 2 1921, and that death occurred, on the date stated above, at 4.50 a. m.

The CAUSE OF DEATH* was as follows:

(a) Broncho Pneumonia

(Duration) ....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary) Measles.

(Duration) ....yrs....mos. 3 ds.

(Signed) Louis V. Gil M. D.

March 3, 1921. (Address) 1601 E Hamilton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	March 4., 1921.

20-UNDERTAKER Jas L. Butler — ADDRESS 2334 Jefferson St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51420 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51420

CERTIFICATE OF DEATH.

91 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Gorman Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward B. Weyrich

(a) RESIDENCE. No. 6 Gorman Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 21 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry J. Weyrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Clara E. Brunner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Henry Weyrich
(Address) 6 Gorman Ave.

15 Filed MAR 3 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to Mar 1, 1921, that I last saw him alive on Mar 1, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ....yrs. ....mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Roll Straus Jr., M. D.

3/2, 1921 (Address) 1938 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	March 4th 1921
20 UNDERTAKER	ADDRESS
Mackey John H. Tenfel & Son	836 W. Fayette

TION is very important. See instructions on

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51421 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51421

CERTIFICATE OF DEATH. 79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 1043½ W. Fayette St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Lillis

(a) RESIDENCE. NO. 1043½ W. Fayette St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white.	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) - 1862 unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Potter. 46

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John. Lillis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret Tobin.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Thomas F. Lilly

(Address) 1045½ W Fayette St.

15 Filed ..... 19.. Robert P. Harrison, Registrar

APR 8 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1920, to March 1, 1921, that I last saw him alive on March 1, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Cusagno, M. D.

March 8, 1921 (Address) 2314 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	3/4/1921
20 UNDERTAKER John J. Cowan & Son	ADDRESS 907 N Gilmor St.

CAUSE OF DEATH in plain terms, so that it may be readily understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51422 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51422

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 N. Calhoun ST.; 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. Mitchell

(a) RESIDENCE. No. 128 N. Calhoun ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. Madison Mitchell

6 DATE OF BIRTH (month, day, and year) May 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George J. Gibney

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Mary A. Bunting

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Joseph D. Gibney (Address) 128 N. Calhoun St.

15 Filed MAR 3 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28th 1921, to Mch 3rd 1921, that I last saw her alive on March 3rd 1921, and that death occurred, on the date stated above, at 11.15 A. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No (Postmortem)

What test confirmed diagnosis? Cold Nitric acid for Albumen

(Signed) M. G. Smith, M. D.

3. 1921 (Address) 182 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mch 5 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 N. Fayette St

CAUSE OF DEATH should be entered by physician in ink or indelibly. Use no abbreviations or ditto marks. Be particular and write plainly. Cause of death must be stated for every case, whether attended during life or not. Indefinite statements, such as "Heart Failure," "Exhaustion," "Septicemia," "Pneumonia," "Tuberculosis," "Cancer," "Kidney Disease," "Paralysis," "Convulsions," "Hemorrhage," "Old Age," "Infantile Debility," "Premature Birth," "Childbirth," "Accident," "Fracture," "Drowning," "Homicide," "Suicide," "Burns," "Found Dead," "Unknown," are not sufficient. Deaths from violence must state the means and nature of injury, and whether accidental, suicidal or homicidal. Deaths occurring in hospitals or institutions must give the street address (number) of the institution, in addition to the name. Deaths occurring while in transit must give the place where the disease was contracted. Deaths occurring in moving conveyances must give the place where the body was removed. Deaths occurring in the city must give the street address (number) of the residence. Deaths occurring outside the city must give the name of the city or town. Deaths occurring on farms must give the name of the county. Deaths occurring in the city must be reported to the Health Department of the city. Deaths occurring outside the city must be reported to the local Registrar of the district. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Bright's Disease

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51423 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51423

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2504 Ellamont ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Garrett Bitter

(a) RESIDENCE. NO. 2504 Ellamont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1- 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. gld

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Bitter

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose McCormick

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant John Bitter

(Address) 2504 Ellamont

15 Filed MAR 3 - 1921 . 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1st, 1921, to Mar 3rd, 1921, that I last saw he alive on Mar. 3rd, 1921, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hart V. Hiss, M. D.

, 19 (Address) 2838 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	March 4- 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave

CAUSE OF DEATH in plain terms, so that a ... TION is very important. See instructions on ... s on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51424 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51424

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Plum alley WARD 23)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Herzog

(a) RESIDENCE. NO. 1213 Plum alley ST., ... WARD. .....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 50 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Herzog

6 DATE OF BIRTH (month, day, and year) Mar 3 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Varnisher

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture fac.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Herzog

(Address) 1213 Plum Alley

15 Filed MAR 3 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1 1921

17

I HEREBY CERTIFY, That I attended deceased from 2/28 1921, to 3/1 1921, that I last saw him alive on 2/1 1921, and that death occurred, on the date stated above, at 3. m.

The CAUSE OF DEATH* was as follows:

Brights disease (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) J. Edw. Linck, M. D.

3/2 1921 (Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul's Cem. Trap Rd.	March 1921
20 UNDERTAKER	ADDRESS
F. A. Hearne & Son	703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MAR 3 - 1921

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51425

CERTIFICATE OF DEATH.

40

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 Scott St ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Dimmie I Hoey

(Residence in Baltimore: No. 203 Scott St St.; 40 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Dec 2, 1878 (Month) (Day) (Year)

7-AGE, 43 yrs. 3 mos. 0 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Easton Md

PARENTS.

10-NAME OF FATHER, Solomon Covey

11-BIRTHPLACE OF FATHER (State or Country), Easton Md

12-MAIDEN NAME OF MOTHER Mary K. Bowdle

13-BIRTHPLACE OF MOTHER (State or Country), Easton Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Solomon Covey

(Address) 203 S Scott St

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

MAR 8 1921 Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 2nd, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1920, to Mar 2nd 1921, that I saw h.. alive on Feb 27th 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. H. Lieter M. D.

Mar 3rd, 1921. (Address) 6.6.6. N. Charles Sts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem

DATE OF BURIAL, 3-4, 1921

20-UNDERTAKER ROBERT BROOKS & SON

ADDRESS Calhoun Hollins sts

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Cooney) Order Maryland Cas Co

20.51426 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51426

CERTIFICATE OF DEATH.

10-15

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1045 Brandy Cor ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Cooney

(a) RESIDENCE. NO. 1045 Brandy Cor ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Lawrence Cooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Coyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Kathrine Cooney

(Address) 1045 Brandy Cor

15 Filed MAR 3 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26" 1921, to Mar. 3 1921, that I last saw h. w alive on Mar. 3" 1921, and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Infirmities of Age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mild Grip

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm B Rider M. D.

19 (Address) 867 Hanover Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Mch 5 1921
20 UNDERTAKER	ADDRESS
Wm Cook	44 S. Mi

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51427 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51427

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 E. Eager St.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ann Samsel

(a) RESIDENCE. NO. 912 E. Eager St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. W. Samsel

6 DATE OF BIRTH (month, day, and year) Oct. 28 1849

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Glendale New Jersey

PARENTS

10 NAME OF FATHER Peter Reilly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Annie Conkling

(Address) 2246 Eastern Ave

15 Filed MAR 3 - 1921, 19.... Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1921, to Mch 1, 1921, that I last saw h.. alive on Mch 1, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chron Int Nephritis & Arterio Sclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Alan B Newman, M. D.

3/3, 1921 (Address) 718 N Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Mar 1921
20 UNDERTAKER	ADDRESS
Elmer W Conkling	2246 Eastern Ave

If any of the preceding items is unknown, say so. Do not state "probably" so-and-so. Make the return as complete as possible. In the case of a stillborn child, write "stillborn" before the word "CAUSE" in the first line of item 17, and omit items 5, 6, 7, 8, 10, 11, 12, 13, 18, 19, and 20. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51428 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51428

CERTIFICATE OF DEATH. 170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 S Paca ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie R. Showacre

(a) RESIDENCE. No. 627 S Paca ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. S. Showacre

6 DATE OF BIRTH (month, day, and year) Nov 17 1835

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	85	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER Samuel Leitch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harkney Lot S C

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Mrs M. S. Showacre (or) S Paca St

15 Filed MAR 3 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 28th, 1924, to March 2nd 24, that I last saw h alive on March 2nd 1924, and that death occurred, on the date stated above, at 2.30A m.

The CAUSE OF DEATH* was as follows:

Edema of the Lungs

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J E Poulton, M. D.

3/13, 1924 (Address) 654 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	March 1924
20 UNDERTAKER	ADDRESS
W. J. Packard Son	Northern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information should be given in every case. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51429 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51429

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4902 Liberty Heights St.: 28 WARD)

2-FULL NAME Susan Alonia Shutz

(a) RESIDENCE. No. 4902 Liberty Heights St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Shutz

6 DATE OF BIRTH (month, day, and year) April 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Northumberland Co Va

PARENTS

10 NAME OF FATHER Baldwin W. Bentley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Frances M Wyckoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

14 Informant Chas E Shutz

(Address) 4902 Liberty Hgts

15 Filed MAR 3 - 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be readily understood. See back of certificates. TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 3 d 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 30th 1921, to Mch 3d 1921, that I last saw h[illegible] alive on Mch 3d 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Paranchymatous Nephritis +
Arteriosclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopical examination

(Signed) A. Colwell, M. D.

Mch 3d 1921 (Address) 4309 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Mch 1921
20 UNDERTAKER	ADDRESS
Wm J Burkert Sons	Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

51430 HEALTH DEPARTMENT—CITY OF BALTIMORE 51430

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 935 Ensor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul. A. Maher

(a) RESIDENCE. NO. 935 Ensor ST., 10 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Singl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 9 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Silver P. Maher

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Frances E. Tilson

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mr. Silver P. Maher
(Address) 935 Ensor St

15 Filed MAR 4 - 1921 [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1921, to March 3, 1921, that I last saw h[illegible] alive on March 3, 1921, and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? By none

(Signed) H. Talmage Owens, M. D.

March, 19 21 (Address) 1206 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 5 1921
20 UNDERTAKER Henry Hoeck & Son	ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nodular Lesion of [illegible]
infection

Spec. 6-9-19—H. P. Co.—1000 Bks.

D51431 HEALTH DEPARTMENT—CITY OF BALTIMORE D51431

CERTIFICATE OF DEATH

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Ashburton St.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen L. Bowles.

(a) RESIDENCE. No. 1801 Ashburton St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 4 - 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	4	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Frederick Bowles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Ida Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Frederick Bowles
(Address) 1801 Ashburton

15 MAR 4 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March. 2. 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1919, to March. 1921, that I last saw h alive on March. 2 1921, and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. L. C. Allen M. D.

3/3/21 (Address) 2757 Wyoming Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	March 5 19
20 UNDERTAKER	ADDRESS
Josiah Syfer.	1600 [illegible]

mation should be carefully written in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly understood. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D51432 HEALTH DEPARTMENT—CITY OF BALTIMORE D51432

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH 1212 Int Royal ave REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Bell Griffith

(Residence in Baltimore: No. 1212 Int Royal ave St.; life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May 15, 1885
(Month) (Day) (Year)

7-AGE, 36 yrs. 9 mos. 19 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Jacob Isanogle

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Florence Bell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry G. Griffith

(Address) 1212 Int Royal Ave.

15- MAR 4 - 1921 Filed ..... 191... [illegible] Registrar.

CAUSE OF DEATH is particularly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 2, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 23 1921, to March 2 1921, that I saw her alive on March 2 1921, and that death occurred, on the date stated above, at 3A. m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY ..... (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. C. Metzel M. D.

March 2, 1921. (Address) 1403 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Druid Ridge Cem.	March 4., 1921.
20-UNDERTAKER	**ADDRESS**
Josiah Syfer	1600 W. North ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51433

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2140 W. Baltimore ST.; 70 WARD)

2-FULL NAME Henry Bittorf

(a) RESIDENCE. NO. 2140 W. Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 11, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm A Bittorf
11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)
12 MAIDEN NAME OF MOTHER Ethelia Taylor
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Wm A Bittorf
(Address) 2140 W Baltimore

15 MAR 4 - 1921 BOARD OF HEALTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1921, to March 1, 1921, that I last saw h-e alive on March 1, 1921, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? Physical

What test confirmed diagnosis?

(Signed) Edward O. Cavlahan M. D.

3/3, 1921 (Address) 24 W Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	March 4 1921.
20 UNDERTAKER	ADDRESS
W E Gosson.	870 W Baltimore

N. B.—... should be carefully supplied. AGE ... mation ... may be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may ... back of certificates. See instructions on back ... TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51434

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51434

CERTIFICATE OF DEATH.

REGISTERED NO. 642

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 627 West Barre ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis L. Scully

(a) RESIDENCE. NO. 627 West Barre ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose A. Scully

6 DATE OF BIRTH (month, day, and year) Feb 28 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: James Scully

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Rose A. Scully 627 W. Barre

15 MAR 4 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1921, to Mar 3, 1921, that I last saw him alive on Mar 2, 1921, and that death occurred, on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

3/3, 1921 (Address) 1 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: March 7 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E North

Hawkins Randall + Charles Sts

mation should be given in plain terms, so that it may be understood by the general public. CAUSE OF DEATH in plain terms, so that it may be understood by the general public. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

5-1435 ✓ 47 5-1435

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3601 Falls Road ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. T. Marks

(Residence in Baltimore: No. 3601 Falls Road St.; 33 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Oct 6, 1829 (Month) (Day) (Year)

7-AGE, 91 yrs. 4 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Edward G. Ford

9-BIRTHPLACE, (State or Country), Frederick Co Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. H. Fulford

(Address) 3601 Falls Road

15- MAR 4 - 1921 ROBERT J. KRAUTER

Filed ....., 191.... Registrar

N.B.—Every item of information should be given in plain terms, so that it may be understood by the laymen. CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. CAUSE OF DEATH is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 2, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to March 2 1921, that I saw h[illegible] alive on March 2 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 6 yrs. mos. ds.

(Signed) R. R. Townsend M. D.

3-3, 1921. (Address) 3544 Charlemont Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sherwood Cem. Cockeysville, DATE OF BURIAL, March 5 1921.

20-UNDERTAKER Horace Burgee & Son ADDRESS 3601 Falls Rd.

D 51436 HEALTH DEPARTMENT--CITY OF BALTIMORE D 51436

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C 29 13

CITY OF BALTIMORE (No. 3422 Cedar ave, St. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Joseph Seward Shutt,

(Residence in Baltimore: No. 3422 Cedar ave St.; 11 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: December 5, 1908 (Month) (Day) (Year)

7 AGE: 12 yrs. 2 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Schoolboy, pd
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: Prestley A. Shutt

11 BIRTHPLACE OF FATHER (State or country): Salto., Md.

12 MAIDEN NAME OF MOTHER: Ethel B. Reynolds

13 BIRTHPLACE OF MOTHER (State or country): Balto., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Prestley A. Shutt

(Address) 3422 Cedar ave,

15 Filed MAR 4 - 1921, 191 ROBERT I. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 2, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August, 1921, to March 2 1921, that I saw him alive on March 1, 1921, and that death occurred, on the date stated above, at 12.30 a.m.
The CAUSE OF DEATH* was as follows:

Chronic valvular heart Disease

(Duration) 1 yrs. 6 mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Geo. W. Dr Hoff M. D.

3/3 1921 (Address) 2020 N. Charles.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: March 4 1921

20 UNDERTAKER: Horace Burgee Sons — ADDRESS: 363 Falls Rd.

N. B.—Every item of information should be carefully supplied. AGE should be given so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51437 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St., 13 Ward) REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Kelly

(a) RESIDENCE. No. 3705 Falls Road St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Jane Kelly

6 DATE OF BIRTH (month, day, and year) April 6-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Elizabeth Maxwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Martha Jane Kelly

(Address) 3705 Falls Road

15 Filed MAR 4 - 1921 Norris I Krauter Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/ 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb-24, 1921, to March 3, 1921, that I last saw him alive on March 3, 1921, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Edema

(Interocurrent)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Physical Signs

(Signed) Eugene Hayward, M. D.

19 (Address) 13 E Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	March 7 1921
UNDERTAKER Horace Burgee & Son	ADDRESS 3611 Falls Rd

nation should be carefully supplied. Age should be given in years, months and days if under one year. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D-51438

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-51438

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 N Gay ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo A Jordan

(a) RESIDENCE. NO. 1215 N Gay ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced—write the word)
Female	White	Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Jordan

6 DATE OF BIRTH (month, day, and year) Jan 15 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Peter Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hannah E Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Jennie Wise
(Address) 1215 N Gay St

15 MAR 4 - 1921

ROBERT E. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1921, to Mar 2, 1921, that I last saw h[er] alive on Mar 2, 1921, and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

Mar 3, 1921 (Address) 1301 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Mar 5 1921

20 UNDERTAKER J Henry & Co

ADDRESS 2008 Eutaw

N. B.—[illegible] should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS, so that it may be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D-51439

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-51439

92-079

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital 326 St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED No.

2-FULL NAME Harry Browne

(a) RESIDENCE. No. 3409 Eutaw Place WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Lilly

6 DATE OF BIRTH (month, day, and year) May 15 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
25	25	9	17	

8 OCCUPATION OF DECEASED Real Estate

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Harrison Browne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Amanda Bentley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Annie Browne

(Address) 3409 Eutaw Place

15 Date Received MAR 4 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 3, 1921, that I last saw him alive on March 3, 1921, and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Physical Signs

(Signed) Alf. Gage, M. D.

. 19 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Mar 7 1921
20 UNDERTAKER J Herwig & Co	ADDRESS 2008 Orleans

mation should be carefully supplied. All items must be properly classified. Exact statement of decedent's CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D-51440 HEALTH DEPARTMENT—CITY OF BALTIMORE Lockmiller D 64 51440

CERTIFICATE OF DEATH. REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1627 Abbott St.; 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelia Lockmiller

(Residence in Baltimore: No. 1627 Abbott St.; 66 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Jan 9, 1844 (Month) (Day) (Year)

7-AGE. 77 yrs. 1 mon. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W D Lockmiller

(Address) 1627 Abbott

15-

Filed MAR 4 1921, 191.... ROBERT S. BRAUNER Registrar.

Burial Permit [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 2, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Kerr Downey M. D. (Coroner.)

191... (Address) 4 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore | DATE OF BURIAL, Mar 6, 1921

20-UNDERTAKER J Kerrigan & Co | ADDRESS 2005 Eutaw

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51441 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51441

CERTIFICATE OF DEATH.

8 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 E Lanvale ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Adam

(a) RESIDENCE. No. 1711 E Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~
HUSBAND of (or) WIFE of (Frederick Adam

6 DATE OF BIRTH (month, day, and year) June 16-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	8	14	

8 OCCUPATION OF DECEASED at home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER George Rauch

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Randolph Landman
(Address) 601 N Linwood Ave

15 MAR 4 - 1921 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Mar 2, 1921, that I last saw her alive on Mar 2, 1921, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. D. Macdonald, M. D.

Mar 3, 1921 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Mar 5 1921
20 UNDERTAKER J. Herwig & Co	ADDRESS 2008 Orleans

N. B.—Information should be carefully supplied. Answers must be written so that it may be properly classified. Each question must be answered. CAUSE OF DEATH in plain terms,

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51442 HEALTH DEPARTMENT—CITY OF BALTIMORE D51442

D51442

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Robt Garrett Hosp

CITY OF BALTIMORE: (No. 27 N. Carey ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret N. Ensey

(a) RESIDENCE. NO. 2624 Maemple Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 5th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Stanley Ensey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Stanley Ensey (Address) 2624 Maemple Place

15 Filed MAR 4 - 1921 ROBERT F. LEAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 26, 1921, to March 2, 1921, that I last saw her alive on March 1, 1921, and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

Tetany

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rachitis & Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. H. V. Cliff, M. D.

3/2, 1921 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem.	March 3d 1921
20 UNDERTAKER A. Jones	ADDRESS 2078 S. Linden Ave

...mation should be carefully supplied. ... so that it may be properly classified. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

951443 HEALTH DEPARTMENT—CITY OF BALTIMORE 92 951443

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 N Carlton ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Smith

(a) RESIDENCE. NO. 107 N Carlton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED Laborer 0440

(a) Trade, profession or particular kind of work Work in market

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer L. Redberg

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Robertson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Amanda Decoursey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Annie Kamm

(Address) 304 S. Pennsylvania Ave

15 Filed MAR 4 - 1921 ROBERT B. KRAETER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1 1921, to March 2 1921,

that I last saw h alive on March 2 1921,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulm Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

March 7 1921 (Address) 939 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	March 3 1921

20 UNDERTAKER A. Jones ADDRESS 237 N. Howard St

Information should be carefully supplied. All items must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(over)

D51444

HEALTH DEPARTMENT—CITY OF BALTIMORE

92D51444

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 N. Wadesa ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Kayes

(Residence in Baltimore: No. 602 N Wadesa St.; ..... yrs., 6 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Mgh

6-DATE OF BIRTH, Aug (Month) 29 (Day), 1920 (Year)

7-AGE, ... yrs. 6 mos. 1 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Kayes

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Fannie Hutchins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Kayes

(Address) 602 N. Wadesa St

15- MAR 4 - 1921 ROBERT B. CHANTER

Filed ....., 191.... Burial Permit ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 2d (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1st 1921, to March 1st 1921, that I saw h[illegible] alive on March 1st 1921, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Child was in last stages of Empyema Pneumonia & died of Exhaustion after operation

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Lynch M. D.

March 2, 1921. (Address) 1917 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cemetery	March 4, 1921.
20-UNDERTAKER	ADDRESS
Milton Davis	413 N Eutaw St

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Answer all questions. Omissions are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

951445 HEALTH DEPARTMENT—CITY OF BALTIMORE. 951445

CERTIFICATE OF DEATH. 135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna C. Stroupp.

(a) RESIDENCE. No. 334 West Lee St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of wife of Charles H Stroupp

6 DATE OF BIRTH (month, day, and year) April 7. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rachael Miles

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Maryland.

14 Informant Husband Charles H Stroupp (Address) 334 W Lee Street

15 Filed MAR 4 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from March 2nd 1921, to March 2nd 1921, that I last saw h alive on March 2nd 1921, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease (Chronic mitral insufficiency).

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Uterine Hemorrhage (Placenta praevia)

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? (Major & Minor) Date of March 2nd 1921

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J Harris Reese, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	MAR 5 1921
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

D51446 HEALTH DEPARTMENT—CITY OF BALTIMORE D51446

CERTIFICATE OF DEATH. REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1015 William St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula Lee Richardson.

(Residence in Baltimore: No. 1015 William St. St.; yrs. ---- mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, September 3rd. 1871., 1 (Month) (Day) (Year)

7-AGE, 49 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Matthews Co. Va.

PARENTS.

10-NAME OF FATHER, John R. Richardson.

11-BIRTHPLACE OF FATHER (State or Country), Matthews Co. Va.

12-MAIDEN NAME OF MOTHER Mary L. Weston.

13-BIRTHPLACE OF MOTHER (State or Country), Matthews Co. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles B. Richardson (Bro.)

(Address) 1015 William St.

15- MAR 4 - 1921 Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 2nd. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an enquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) (Duration) .....yrs.....mos.....ds.

(Signed) Wm. E. Reinhardt M. D. (Coroner.)

March 4 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 16 ds. In the State.....yrs.....mos. 16 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Matthews Co. Va.

19-PLACE OF BURIAL OR REMOVAL, Fairhotta P.O. Matthews Co. Va. via B.C.&A. R.R.

DATE OF BURIAL, MAR. 6, 1921

20-UNDERTAKER JOHN F. DENNY

ADDRESS 715 LIGHT ST.

N.B.—Every item of information should be carefully supplied. Exact statement of occupation is necessary that CAUSE OF DEATH may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is necessary that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44033 D51447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51447

CERTIFICATE OF DEATH.

X36

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Hunter

(a) RESIDENCE. NO. Glen Arms Balto Co. Md ST.. WARD. Glen Arm Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Oct 17- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Charles Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) J.H.H. Records

15 Filed MAR4-1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1921, to March 2, 1921, that I last saw h.r alive on March 2, 1921, and that death occurred, on the date stated above, at 7 50 P m.

The CAUSE OF DEATH* was as follows:

Rickets

.....(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) —

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? X ray

(Signed) W. R. Davison, M. D.

3-3, 1921 (Address) J H H Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cmtry	Mar 4th 1921
20 UNDERTAKER	ADDRESS
Mrs Robt a Elliott	Oakland Md

N. B.—WRITE with pen and ink. All information should be carefully supplied. ALL BLANKS must be properly classified. Exact CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51448

30

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST.; 76 WARD)

2-FULL NAME Rose Becker

(a) RESIDENCE. No. 3307 Clifton Court ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26-1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Daniel Huber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Emma Spangler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Daniel Huber

(Address) 3307 Clifton Court

15 Filed MAR 4 - 1921 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 2, 1921, that I last saw her alive on March 2, 1921, and that death occurred, on the date stated above, at 10-10 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Chas A Donovan, M. D.

....., 19 (Address) 6-E Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	March 6 1921
20 UNDERTAKER Birkler & Birkler	ADDRESS 1737 E. Eager

mation should be carefully written, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—K. F. Co.—1000 Bks.

D 51449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51449

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2422 Lauretta Avenue ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Downey

(a) RESIDENCE. No. 2422 Lauretta Avenue ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Crain

6 DATE OF BIRTH (month, day, and year): July 24, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer): B. & O. Railroad

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Edward Downey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Gaynor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Mary Downey

(Address): 2422 Lauretta Avenue

15 Filed MAR 4 - 1921 19

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 2 1921

17

I HEREBY CERTIFY, That I attended deceased from December 7, 1920, to March 2, 1921,

that I last saw him alive on March 2, 1921,

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 1920

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. S. Gerry, M. D.

2/6, 1921 (Address) 222 W. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	3/5 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B. Information should be carefully supplied so that it may be properly transcribed. CAUSE OF DEATH in plain terms, so that it may be properly transcribed. CAUSE OF DEATH in plain terms, so that it may be properly transcribed. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51450

108

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. 821 Lake drive ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Ambrose

(a) RESIDENCE. NO. 821 Lake drive ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Vincent Ambrose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Theresa Milowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant James Ellerton

(Address) 2120 Eutaw Pl

BUREAU OF BEAUTIES

15 MAR4 - 1921 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 3, 1921, to Mar. 4, 1921, that I last saw her alive on Mar. 4, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Acute Suppurative appendicitis (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Mar. 3, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. McElwain, M. D.

, 19 (Address) St. Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL May 7 1921

ADDRESS 1916 Eutaw Pl

20 UNDERTAKER Frank Graeter

N. B.—WRITE plainly. All items should be carefully supplied. Any information should be properly classified, so that it may be of use. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

251451 Deventi

HEALTH DEPARTMENT—CITY OF BALTIMORE 251451

CERTIFICATE OF DEATH.

REGISTERED No. C 167

(PLACE OF DEATH

CITY OF BALTIMORE (No. St Joseph Hospital St.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Teresa Deventi

(Residence in Baltimore: No. 255 East ave

Life

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov 6 (Month) (Day), 1917 (Year)

7-AGE, 3 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), N D

PARENTS.

10-NAME OF FATHER, Philipp Deventi

11-BIRTHPLACE OF FATHER (State or Country), Itla

12-MAIDEN NAME OF MOTHER Irene Salvi

13-BIRTHPLACE OF MOTHER (State or Country), Itla

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philipp Deventi

(Address) 255 East st

15- MAR 4 - 1921 REGISTRAR

Filed ....., 191.

Burial ... Undertaker

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 3 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, pulled down

Hours (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. L. Kingsley M. D.

(Coroner)

3-3, 1921 (Address) 45 E. Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Vincent

DATE OF BURIAL, Mar 5 1921

20-UNDERTAKER Greenwald & Co

ADDRESS 6 Pentrayt ave

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51452

CERTIFICATE OF DEATH.

170

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 Fair oaks ave ST.; 9 WARD)

2-FULL NAME Thomas Henry Newton

(a) RESIDENCE. No. 634 Fair oaks ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Newton

6 DATE OF BIRTH (month, day, and year) 30 April 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Isaac H. Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mary E. Weidner
(Address) 634 Fair Oak Ave.

15 MAR 4 - 1921 [illegible] BAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1921, to March 4, 1921, that I last saw h[illegible] alive on March 3, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Haas, M. D.

3-4, 1921 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrison Forest	Mar 7th 1921
20 UNDERTAKER	ADDRESS
Mrs Johannah Candler	946 Virginia Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated LAST. Exact statement of DECEASED'S mation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51453 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51453

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Mens Home (St.;) 19 (Ward) 6th

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Sharar Stewart

(a) RESIDENCE. NO. 1400 W Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Wid.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1834.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Non pol

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bacc. Md

PARENTS

10 NAME OF FATHER Wm Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ellicott City Md

12 MAIDEN NAME OF MOTHER Clarissa E. Sharar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Mrs H W. Dickman Matron

15 Filed MAR 4 - 1921 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACTION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 27, 1921, to March 3, 1921,

that I last saw h alive on March 3, 1921,

and that death occurred, on the date stated above, at 6 40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteria-Sclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

(Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Weston Cemetery	March 5, 1921

20 UNDERTAKER George J Smith ADDRESS 1000 W Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51454 HEALTH DEPARTMENT—CITY OF BALTIMORE D51454

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hospital ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise DeAngelis

(a) RESIDENCE. No. Nursery & Childs Hospital ST.... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not Employed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Frank DeAngelis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Dundeon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Mary DeAngelis
(Address) 445 N. Calvert St.

15 Filed MAR 4 - 1921 19.... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1921, to March 4, 1921, that I last saw h W alive on March 4, 1921, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ✓ Date of .....

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) L. J. Feinglass, M. D.

, 19 (Address) 2002 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 5, 21
20 UNDERTAKER George J. Smith	ADDRESS 2000 E Fayette St.

N. B.—WRITE PLAINLY with pen and ink. Information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec. 6-9-19—H. P. Co.—1000 Blks.

dh 51455 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51455

CERTIFICATE OF DEATH. 98

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO 14 Warner St. Wd. West 25 WARD)

2-FULL NAME Samuel Tyler

(a) RESIDENCE. NO. 14 Warner St. Wd. West WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 8, 1868

7 AGE Years 51 Months 11 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Cis Tyler (Address) Nat. Wounds Md

15 Filed MAR 4 - 1921 Robert P. Harrison Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/16 1921 to 2/28 1921 that I last saw him alive on 2/28 1921 and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Uremia Pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Fracture of Left Side (duration) 2 yrs. mos. ds. 7-8-9

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. B. Turnbull Jr., M. D.

3/1/1921 (Address) 1216 D. H. Or.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Edw. Young Gold. DATE OF BURIAL Mar. 4 1921

20 UNDERTAKER Edw. Young Gold ADDRESS 1463 Carey St 1463 Carey St

N. B.—WRITE PLAINLY. All items must be carefully supplied. Age should be properly classified. Each question must be answered. Information should be carefully supplied. Age should be properly classified. Each question must be answered. Information should be carefully supplied. Age should be properly classified. Each question must be answered. Information should

No. 51456 HEALTH DEPARTMENT—CITY OF BALTIMORE No. 51456

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. City of Baltimore (No. Mercy Hospital St.: No Ward) REGISTERED No. C 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Kroll.

(Residence in Baltimore: No. 4506 Eastern Ave (East) St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. Nov. 27 1869 (Month) (Day) (Year)

7-AGE. 51 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Butcher
(b) General nature of industry, business, or establishment in which employed (or employer). Fellmayer & Son

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. John Kroll

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Kroll

(Address) 4506 Eastern Ave

15- Filed MAR 4 - 1921, 191.... Robert P. Harrison Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Mar 2 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) yrs. mos. ds.

(Signed) G. Lotulon Blatt M. D. (Coroner)

3/4/21, 191... (Address) 1437 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem	March 5 1921
20-UNDERTAKER. Lilly & Zeller.	ADDRESS 403 S. Howard

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—11. P. Co.—1000 Bks.

D.51457 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4517 Eastern Ave ST.; 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine M. Porter

(a) RESIDENCE. NO. 4517 Eastern Ave ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Porter

6 DATE OF BIRTH (month, day, and year) Aug 19 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Philip Rodowsky

(Address) 402 Eastern Ave

15 Filed . 19 Robert P. Harrison Registrar

MAR 4 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1921, to March 3rd, 1921, that I last saw her alive on March 3rd, 1921, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Senility + Hemorrhage of Brain

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	March 5 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE should be given in every case. Information should be carefully supplied. Date of death must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Date of birth must be given. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51458 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51458

CERTIFICATE OF DEATH. 47

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Franklin Square Hospital ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Bacon

(a) RESIDENCE. No. 815 E. Baca ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. M. Bacon.

6 DATE OF BIRTH (month, day, and year) Dec 29-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Euler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Steinz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Estelle Schumin

(Address) 815 E. Baca St

15 Filed ..... 19 ..... Robert P. Barrick Registrar

MAR 7 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/21, 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...

that I last saw h e alive on March 3, 1921,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2/26/21

Was there an autopsy? no

What test confirmed diagnosis? Tissue diagnosis

(Signed) A S Abbott, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL March 7 - 1921

20 UNDERTAKER William Cook

ADDRESS 502 E. Hatt Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. Age should be properly classified. Exact statements may be important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51459

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51459

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Aliceanna St. 23 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Hundertmark

(a) RESIDENCE. No. 1626 Clinton St. 23 Ward. Towson Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Hundertmark

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Conrad Hundertmark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Nabis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm H. Hundertmark (Address) 217 Cedar Ave

15 Filed MAR 4 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1921, to Mar 4, 1921, that I last saw h— alive on Mar 4, 1921, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. P. Campbell, M. D.

Mar 4 19 21 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Towson	Mar 6 19 21
20 UNDERTAKER John Bosley & Sons	ADDRESS Towson

B.—WRITE PLAINLY with pen and ink. All information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. Date of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51460 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51460

CERTIFICATE OF DEATH. X 176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Morrow Hospital 1122 N. Mount St ST.; 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Hawkins.

(a) RESIDENCE. No. 1122 N. Mount St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	84	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired School Teacher D68

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Holland Hawkins

(Address) La Plata Md

15 Filed MAR 4 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3" 1921

17 I HEREBY CERTIFY, That I attended deceased from November 22 1920, to March 3, 1921, that I last saw him alive on March 3, 1921, and that death occurred, on the date stated above, at 1.35 P/m.

The CAUSE OF DEATH* was as follows:

Uremic toxemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hypertrophy of prostate

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 5 1921.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John S McDowell, M. D.

, 19 (Address) Morrow Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairfountain Chas. Co. Md	3/5 1921
20 UNDERTAKER	ADDRESS
Chas J Evans & Son	18 Mt Royal Ave

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE should be given in years, months and days, and if less than one day the hours or minutes should be stated. If the information should

D. 51461

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D. 51461

1-PLACE OF DEATH

29

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1122 Druid Hill Ave ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Everton

(Residence in Baltimore: No. 1122 Druid Hill Ave St. 39 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female | 4-COLOR OR RACE: Black | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: July (Month) 4 (Day), 1861 (Year)

7-AGE: 59 yrs. 7 mos. 27 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE (State or country): Va.

PARENTS

10-NAME OF FATHER: Harold

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Viola Dorsey

(Address) 1122 Druid Hill Ave

15. Filed ....., 191.... Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MAR 4 - 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 3 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1921, to March 3 1921.
that I saw h.. alive on March 2, 1921.
and that death occurred, on the date stated above, at 8 A. m.
The CAUSE OF DEATH* was as follows: Mitral insufficiency

(Duration) Several years

Contributory (SECONDARY) Acute Bronchitis

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) W. C. Syme M. D.

March 3, 1921 (Address) 1405 E. Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Laurel Cmty | DATE OF BURIAL: Feb 6, 1921

20-UNDERTAKER: George H. Holland | ADDRESS: 1631 Druid Hill Ave

WRITE PLAINLY. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. INFORMATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51462 HEALTH DEPARTMENT—CITY OF BALTIMORE D51462

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Cypress ST.; 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antanina Povilaitis

(a) RESIDENCE. NO. 21 Cypress ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56	—	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS
10 NAME OF FATHER noxon
11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania
12 MAIDEN NAME OF MOTHER noxon
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Nellie Milenniss
(Address) 644 W Lombard St

15 Filed Robert P. Harrison, Registrar
MAR 4 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1921

17 I HEREBY CERTIFY, That I attended deceased from January 15 1921 to Mar. 3 1921.
that I last saw her alive on Mar. 2 1921.
and that death occurred, on the date stated above, at 12 — m.
The CAUSE OF DEATH* was as follows:

a) Pneumonia — duration

CONTRIBUTORY (Secondary) diabetes mellitus (duration) 10 yrs. — mos. — ds.

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Sputum
(Signed) A Rubenstein, M. D.
, 19 (Address) 1340 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	March 6 1921
20 UNDERTAKER	ADDRESS
John Grebliunas	425 S. Paca St.

N. B.—WRITE PLAINLY. All items should be carefully supplied. Age information should be carefully supplied, so that it may be properly classified. Each CAUSE OF DEATH in plain terms, so that it may be properly classified. Each CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tubercular

Stat. 6-9-19 H. & C. Co. 1000 Bks.

D.51463 D.376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 92

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Watts

(a) RESIDENCE. No. 217 N. Bethel St ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21 - 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James Watts

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Julia Hawkins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant
(Address) Johns Hopkins Hosp.

15 Filed Robert P. Harrison, Registrar

MAR 4 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 18. 1921, to March 1st 1921, that I last saw h[illegible] alive on March 1st 1921, and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X ray

(Signed) W C Dawson, M. D.

March 5, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health, MAR 3 - 1921

WOODALL

N. B.—WRITE PLAINLY. Ink should be used. All information should be carefully supplied. AGE should be properly classified. Exact information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51464

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2905 Hudson ST.: 1 WARD) 79 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Gallagher

(a) RESIDENCE. No. 2905 Hudson ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Margaret Gallagher

6 DATE OF BIRTH (month, day, and year) aug - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town). (State or country) Ireland

PARENTS

10 NAME OF FATHER James Gallagher

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mary Gallagher
(Address) 2905 Hudson St

15 Filed MAR 4 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 2 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Mch 2, 1921, that I last saw h[im] alive on March 2, 1921, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. J. McAvoy, M. D.

3/3 1921 (Address) 836 O. Ellwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mch 5 1921

20 UNDERTAKER	ADDRESS
J. A. Moran	3000 E. Balto.

N. B.—WRITE PLAINLY. All information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51465 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51465

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD) 25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Darius Warner

(a) RESIDENCE. No. 532 N. Main St. Sidney WARD. Ohio

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Rosetta Warner

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs. Rosetta Warner

(Address) 532 N. Main St Sidney Ohio

15 Filed ..... 19 Robert P. Harrison, Registrar

MAR 4 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-25, 1921, to 3/3, 1921,

that I last saw him alive on 3/3, 1921,

and that death occurred, on the date stated above, at 11:55 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the descending Colon

Metastasis to Liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

Pulmonary Edema (duration) 24 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Ohio

Did an operation precede death? Yes Date of 1-25-21

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) W. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sidney-Ohio	Mar 4 1921
20 UNDERTAKER F. B. Stippert 2236	ADDRESS Frederick Ave

N. B.—Information should be carefully supplied so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51466 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51466

CERTIFICATE OF DEATH. 153

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Myrtle Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcia Jones

(a) RESIDENCE. No. 1312 Myrtle. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3-1-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Izetta Nickens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alberta Nickens
(Address) 1312 Myrtle Ave

15 Filed MAR 4 - 1921, 19 Robert F. Hartman Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 2, 1921, that I last saw her alive on March 2, 1921, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Child was born Two hours before Physician was sent. Death was due to Apnoea

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Same Form

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. B. Fisher, M. D.

, 19 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	3-4 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Ostend St

N. B.—WRITE PLAINLY. WITH ... mation should be carefully supplied. AGE should be stated ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51467 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51467

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Johnson

(a) RESIDENCE. No. 500 W. Hoffman st. ST., WARD.
(Usual place of abode) (7 years) (If nonresident give city or town and State)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Virginia

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address) H.T.H.

15 Filed MAR4-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1920, to March 2, 1921, that I last saw her alive on March 2, 1921, and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum; X-ray

(Signed) L. Rigney, M. D.

3-3-21. (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Lincoln Cem	Mar 6th 1921

20 UNDERTAKER ADDRESS
Jas. M. Skinner 1625 E. Madison St

N. B.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of occupation should be stated. AGE should be carefully supplied. Exact statement of birthplace and parentage should be properly classified. AGE should be carefully supplied. Exact statement of occupation should be stated. EXACT information should be carefully supplied

D.51468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51468

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE (No. 1011 Madison ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clyde Schooler

(Residence in Baltimore: No. 1011 Madison Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, ... March 3, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 4 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Clyde Schooler

11-BIRTHPLACE OF FATHER (State or Country): Tenn.

12-MAIDEN NAME OF MOTHER: Margaret Howell

13-BIRTHPLACE OF MOTHER (State or Country): N.C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Clyde Schooler

(Address) 1011 Madison Ave

15- MAR 4 1921 Robert P. Harrison,
....., 191.....
Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Mar. 3 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquiry .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... Inquiry .....
(Inquest, autopsy or inquiry) find that said deceased came to ..... death from
on the day stated above.
The CAUSE OF DEATH* was as follows:

As Phyxial Neon

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Stadt M. D.
(Coroner.)
3/4/21 191... (Address) 143 N. Bray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross, Md. DATE OF BURIAL, ..., 192..

20-UNDERTAKER Howe Cook & Son ADDRESS Balto

WRITE PLAINLY, WITH INK.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51469

CERTIFICATE OF DEATH.

REGISTERED NO. 55

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Norden

(a) RESIDENCE. NO. 213 Maryland ave Balto Md WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Johnson. (dead)

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER (dead)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant J. H. Friend
(Address)

15 Filed MAR 4 - 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28. 1921, to March 3, 1921, that I last saw h[illegible] alive on March 3, 1921, and that death occurred, on the date stated above, at 12 50 P m.

The CAUSE OF DEATH* was as follows:

Purpura hemorrhagica

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Studies

(Signed) W. Davison, M. D.

3-3. 1921 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	May 7 1921
20 UNDERTAKER	ADDRESS
Lowe Cook Sons & Hollis	

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of DATE OF BIRTH and AGE should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51470 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51470

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 Hennaman av ST.; 8 WARD) 113 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Schriefer.

(Residence in Baltimore: No. 2213 Hennaman St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan. 7, 1851. (Month) (Day) (Year)

7-AGE, 70 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Michael Schriefer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Dietz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Helen Hammel

(Address) 2213 Hennaman Ave

15-

Filed MAR 4 - 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7, 1921, to March 3, 1921, that I saw him alive on March 2, 1921, and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar, Acute

Regurgitation

(Duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 10 ds.

(Signed) Albert E. Simonds M. D.

3/4/, 1921. (Address) 1610 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, 3/4/, 1921.

20-UNDERTAKER Geo. J. Ruth ADDRESS 1735 Hanford Ave

N.B.—Every item of information should be carefully supplied. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51471 — 51471

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hosp 8 W

CITY OF BALTIMORE, NO. 903 N Bond ST.; WARD)

2-FULL NAME Cecelia Ella Mullahey

(a) RESIDENCE. NO. 903 N Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White.

5 (Single), Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3, 1919

7 AGE — Years: 1 — Months: 9 — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) child

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward Herman Mullahey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Anna M. Ullrich.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Anna Ullrich (mother)
(Address) 903 N Bond ST.

15 Filed MAR 5 - 1921, 19 ... Robert F. Carrigan, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1920, to March 3, 1921, that I last saw her alive on March 3, 1921, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Surgical Operation for dilatation of stricture of Larynx

(duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary) Surgical shock (1)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 3, 21

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John W. Baylor, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. — DATE OF BURIAL: March 5 1921

20 UNDERTAKER: Frank A. Tieck — ADDRESS: 910 N Gay St

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

D.51472 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51472

CERTIFICATE OF DEATH. X 120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 414 N Payson ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samtha Bean

(Residence in Baltimore: No. 414 N Payson St.; yrs., mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, April (Month) 22 (Day), 1851 (Year)

7-AGE, 69 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Indiana

PARENTS.

10-NAME OF FATHER, Shaw

11-BIRTHPLACE OF FATHER (State or Country), Indiana

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles A. Nicholls

(Address) 414 N. Payson

15- Robert P. Harrison, Registrar.

Filed MAR 5 1921, 191.....

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration)..... yrs. 10 mos..... ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart Sudden (Duration)..... yrs..... mos..... ds.

(Signed) James M Fenton M. D. (Coroner.)

Mar 4, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cemetery	Mar 5, 1921
20-UNDERTAKER George J Smith	ADDRESS 1000 Fayette

Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51473

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 Westwood Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Miller

(a) RESIDENCE. No. 1727 Westwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Wm. S. Miller

6 DATE OF BIRTH (month, day, and year) Sept. 3rd 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Peter Emory

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Wm. A. A. Bantel

(Address) 3816 Banner Road.

15 MAR 5 - 1921 Robert P. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 28, 1921, to March 4, 1921, that I last saw h.Er alive on March 3, 1921, and that death occurred, on the date stated above, at 9.40 A.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (Left side) both lobes

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Heart Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Robert W. Mifflin, M. D.

, 19 (Address) 1016 Mad. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 7 1921
20 UNDERTAKER	ADDRESS
Henry Hoerle Sons	1301 E Eager

N. B.—WHILE LEARNED PHYSICIANS are frequently supplied. AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be given in every case, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51474

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51474

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 N. Caroline ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elisha G. Bacon

(a) RESIDENCE. No. 1209 N. Caroline ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the Word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida F. Bacon

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 31

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Maryland

PARENTS

10 NAME OF FATHER William Bacon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Maryland

12 MAIDEN NAME OF MOTHER Martha Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Maryland

14 Informant Ida G Bacon

(Address) 1209 N. Caroline St

15 Filed Robert P. Harrison, Registrar

MAR 5 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4, 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1921, to Mar. 4, 1921, that I last saw him alive on March 4, 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

3, 5. 1921 (Address) 1223 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Mar 7 1921
20 UNDERTAKER	ADDRESS
John D. Spencer	1325 N. Caroline St

N. B.—WRITE PLAINLY. All questions should be answered. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of PLACE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51475

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51475

CERTIFICATE OF DEATH.

64

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 138 Collins Ave ST.: 70 WARD)

2-FULL NAME Martha C. Klein

(a) RESIDENCE. No. 138 Collins Ave ST., 70 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. — mos. 19 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph F. Klein

6 DATE OF BIRTH (month, day, and year) Feb 13th 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wm. Bolte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Elizabeth D. Feudester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Joseph F. Klein
(Address) 138 Collins Ave

15 Filed 19 Robert P. Harrison Registrar

MAR 5 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/4 1921, to 3/5 1921,
that I last saw her alive on 3/4 1921,
and that death occurred, on the date stated above, at 3.10 A. m.

The CAUSE OF DEATH* was as follows:

Hemoplegia
Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bright's disease

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted
If not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F. E. Speaks, M. D.

(Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Mar 7 1921

20 UNDERTAKER H. D. Nippert ADDRESS 2334 Eutaw

N. B.—WRITE PLAINLY. Words should be spelled out. All information should be carefully supplied. AGE should be given in full. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

D.51476

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51476

HEALTH DEPARTMENT—CITY OF BALTIMORE

91

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Retreat ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas L Sheffield

(a) RESIDENCE. No 1903 Retreat ST. 15 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1st 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1920	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city ~~or town~~) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Henry L Sheffield

11 BIRTHPLACE OF FATHER (city ~~or town~~) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary L Mitchell

13 BIRTHPLACE OF MOTHER (city ~~or town~~)
(State or country) Md

14 Informant Henry L. Sheffield
(Address) 1903 Retreat St

15 Filed Robert P. Harrison, Registrar

MAR 5 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1921, to Mar 4, 1921, that I last saw h[illegible] alive on Mar 4, 1921, and that death occurred, on the date stated above, at 12.40 ?.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?..

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Paul Brown, M. D.

3/4. 1921 (Address) 1837 Pa Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar 5 1921

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1827 W Fayette St

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

10.51477

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.51477

CERTIFICATE OF DEATH.

92-010

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 N Edw St; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs A Mitchelling

(Residence in Baltimore: No. 1317 N Edw St; 5 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, May 17, 1851
(Month) (Day) (Year)

7-AGE, 69 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 431

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm H Mitchelling

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Edith E. Carter

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm A Mitchelling

(Address) 1317 N Edw St

15-

Filed ....., 191.... Registrar.

Robert P. Harrison,

Burial Permit Clerk.

MAR 5 - 1921

N.B.—Every item of information should be carefully supplied. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements are important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1 1921, to March 3 1921, that I saw h.. alive on March 2 1921, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

..., 191... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Back Cemetery — DATE OF BURIAL, Mar 5, 1921

20-UNDERTAKER Robt J Turner Son — ADDRESS 1424 Pby

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51478 Epsilon 64 D.51478

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Loney Lane Near Forest St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James L Devlin

(Residence in Baltimore: No. Loney Lane Near Forest St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug 8, 1853
(Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland Co

PARENTS.

10-NAME OF FATHER, James Devlin

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Ellen Lennee

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Devlin

(Address) Loney Lane Near Forest

15-

Filed, 1921 Robert P. Harrison, Registrar.

MAR 5 - 1921 Burial Permit Clerk

N.B.—Every item of information should be carefully supplied. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of Sex, Color, Age, Occupation, Birthplace, Residence, etc., are important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 3, 1921.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Feb 27 1921, to Mar 3 1921, that I saw h[illegible]live on Mar 2 1921, and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 4 yrs. mos. ds.

(Signed) J. E. Bennett [illegible] M.D.

Mar 4, 1921 (Address) 10 S. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Mar 7, 1921.

20-UNDERTAKER Robt J Timmons ADDRESS 1424 Bway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51479
9-091

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jaskulski

(a) RESIDENCE. NO. 617 S Bond ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Jaskulski

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Rose Byer

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Frank Jaskulski (Father)
(Address) 2204 Conway St.

15 Filed MAR 5 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1 1921 to March 4 1921 that I last saw him alive on March 4 1921 and that death occurred, on the date stated above, at 3:25 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal,

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none - culture neg.

(Signed) B. MacGowan M. D.

3/4/ 1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery

DATE OF BURIAL March 5" 1921.

20 UNDERTAKER M. F. Sadowski

ADDRESS 705 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of DATE OF BIRTH and AGE should be carefully supplied. AGE should be properly classified

Stmc. 6-9-19—H. P. Co.—1000 Bks.

D.51480

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51480

+92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Covington.

(a) RESIDENCE. NO. Laurel Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. H. Covington

6 DATE OF BIRTH (month, day, and year) Oct 1 - 1871.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware.

PARENTS

10 NAME OF FATHER James Dyer

11 BIRTHPLACE OF FATHER (city or town) Delaware. (State or country)

12 MAIDEN NAME OF MOTHER Emily Redden

13 BIRTHPLACE OF MOTHER (city or town) Maryland. (State or country)

14 Informant Md Genl. Hosp. (Address)

15 Filed MAR 5 - 1921, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1921, to March 4, 1921, that I last saw h EV alive on March 4, 1921, and that death occurred, on the date stated above, at 11.55 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Not Residence

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Fred J. Bamfield, M. D.

3/4. 1921 (Address) Md. Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md.	3-5 1921
20 UNDERTAKER Edward B Hall	ADDRESS 115 E Main St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51481

CERTIFICATE OF DEATH.

170

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3321 Chestnut Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry M. Bull

(Residence in Baltimore: No. 3321 Chestnut Ave St.; 1yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 10 (Month) (Day), 1887 (Year)

7-AGE, 33 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John Bull

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Asked But Known

13-BIRTHPLACE OF MOTHER (State or Country), Asked But Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry M. Bull

(Address) 3321 Chestnut Ave

15- Filed ....., 191.... Registrar.

Robert P. Harrison,
Burial Permit Clerk.

MAR 5 - 1921

N.B.—Every item of information should be carefully supplied. AGE must be correctly stated. Exact statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 2 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from February 1 1921, to March 2 1921, that I saw h[illegible] alive on March 2 1921, and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstatual Nephritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) 2 yrs. mos. ds.

(Signed) A. J. Dawson M. D.

3-4, 1921 (Address) A. J. Dawson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden DATE OF BURIAL, Mar 5, 1921

20-UNDERTAKER A. S. Marshall ADDRESS 3589 Falls Rd

D. 51482

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24/20

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 Warren Ave ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edmond Price

(a) RESIDENCE. NO. 107 Warren Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara C Price

6 DATE OF BIRTH (month, day, and year) May 7th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cloth Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas L. Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co Md

12 MAIDEN NAME OF MOTHER Alverta North

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

11 Informant Clara C. Price

(Address) 107 Warren Ave

15 Filed 19 Robert P. Harrison, Registrar

Daniel Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1st 1920, to March 3rd 1921, that I last saw him alive on March 3rd 1921, and that death occurred, on the date stated above, at 12.10A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 11 mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? So not know

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Examination of Urine

(Signed) H. J. Carrick, M. D.

19 (Address) 1127 N. Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK

DATE OF BURIAL MAR 7 1921

20 UNDERTAKER JOHN F. DENNY

ADDRESS 715 LIGHT St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—11. P. Co.—1000 Bks.

D.51483

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51483

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 W Lexington ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Brown

(a) RESIDENCE. NO. 1628 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Negro	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Brown

6 DATE OF BIRTH (month, day, and year) Feb 2 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis
(State or country) Md.

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Eliza Porter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Annapolis Md

14 Informant Geo Brown (Husband)
(Address) 1628 W Lexington

15 Filed MAR 5 - 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2- 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1920, to Mar 2, 1921, that I last saw h[illegible] alive on Mar 2, 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency
Broncho pneumonia

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 29 yrs. mos. ds.

(duration) 1 yrs. 6? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Wells Jackson M. D.

, 19 (Address) 1618 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 5 1921
20 UNDERTAKER Brown & Copland	ADDRESS 1140 Scheeler

MARGIN MUST BE KEPT CLEAR

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

D. 51484 HEALTH DEPARTMENT—CITY OF BALTIMORE. D. 51484

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of Baltimore (No. Md Gen'l Hospital 24 St. 64 Ward) Registered No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucas Marmor

(Residence in Baltimore: No. 635 E Fres ave. St. yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	M

6-DATE OF BIRTH Dec 30, 1874
(Month) (Day) (Year)

7-AGE, 46 yrs. 3 mos. ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Jack D. Marmor

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Francis D

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Baltimore

15- Robert P. Harrison,

Filed ....., 191.....

MAR 5 - 1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 4, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage 2 hrs.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. ... mos. ... ds.

(Signed) J C Yates M. D.
(Coroner.)

3-5-21, 191... (Address) 1411 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs.....mos.....ds. In the State ....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Hebrew Cem	3/6/21, 19...
20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51485 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51485

CERTIFICATE OF DEATH. 92-072

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Dyson

(a) RESIDENCE. NO. 121 S. Poppleton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Dyson

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Cavanaugh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Clansey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Charles A. Dyson
(Address) 121 S. Poppleton St.

15 Filed Robert P. Harrison, Registrar

MAR 5 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21/1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1921, to March 2, 1921, that I last saw h. alive on March 2, 1921, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ....yrs. His mos. 9 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs not Sputum

(Signed) Bernard J. Lowe, M. D.

3/3, 1921 (Address) 918 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mar. 7" 21
20 UNDERTAKER Joseph B. Cook	ADDRESS 1013 W Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

20.51486

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51486

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1641 Covington ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary E Linthicum

(Residence in Baltimore: No. 1641 Covington St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PRECISE AGE is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June 24 (Month) (Day), 1831 (Year)

7-AGE, 89 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Philip Kirkwood

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Turner

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dana Linthicum

(Address) 1641 Covington

15-

MAR 5 1921, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 10 1921, to March 3 1921,
that I saw h-er alive on March 3 1921,
and that death occurred, on the date stated above, at 9.25 P m.
The CAUSE OF DEATH* was as follows:

(a) Chronic nephritis

.....

.....

from which (Duration) Yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Cushman M. D.

(Address) 3600 Harford Rd

Mar 4 1921

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Mar 7th, 1921

20-UNDERTAKER E. Pennington

ADDRESS 1460 Battery Ave.

HESS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

10.51487

10.51487

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Woman's Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Sue Hess

(Residence in Baltimore: No. Womans Hospital St.; ...yrs., ...mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Unknown, 1894.
(Month) (Day) (Year)

7-AGE, 26 yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Henry C Reeves

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Susan M. Reeves

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry C. Reeves

(Address) Gallinas

15-

Filed MAR 5 - 1921 Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 5, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1921, to March 5 1921, that I saw her alive on March 5, 1921, and that death occurred, on the date stated above, at 1 00 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis Tuberculous
Intestinal Obstruction and
Ovarian

(Duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculous Salpingitis.

Ovarian (Duration) ...yrs. ...mos. ...ds.

(Signed) Frank Worthington M. D.

March 5, 1921 (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 9 ds. In the State ...yrs. ...mos. 9 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Waynesboro, Pa

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Waynesboro Pa	Mar. 5th, 1921.
20-UNDERTAKER	ADDRESS
Chas. E. Ware & Son	11 Mont Royal Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51488 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51488

CERTIFICATE OF DEATH. 1920

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 S. Dallas St (ST.:) 3 (WARD)

2-FULL NAME George H. Thompson

(a) RESIDENCE. NO. 111 S. Dallas ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Anna J. Thompson

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Dwight Kurow.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Albert Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary Paetron

(Address) 109 N. Dallas St

15 Filed MAR 5 - 1921 Robert T. Farriner Registrar

Burial Permit Cleared

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-12-, 1920, to 3-3-, 1921, that I last saw h living live on 2-3, 1921, and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis, etc

several (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia, etc several (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms indicated.

(Signed) Crawford Bowie M. D.

4/3/1921 (Address) 414 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Cemetery	Mar 6th 1921
20 UNDERTAKER Chas. S. Bailey	ADDRESS 1421 Jefferson St

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51489

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51489

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 658 Bradley ST.: 17 WARD)

2-FULL NAME Mary E. Payne

(a) RESIDENCE. NO. 658 Bradley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Blk	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — — 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 071

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisa Co Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Daniel Easton
(Address) 916 Eutaw ave

15 Filed MAR 5 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from January 17, 1921, to March 4, 1921, that I last saw her alive on March 1, 1921, and that death occurred, on the date stated above, at 6.45 m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
(duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) General Dropsy
(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Gustav Goldman, M. D.

19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 6 1921
20 UNDERTAKER Daniel Easton	ADDRESS 916 Eutaw

MARGIN RESERVED FOR BINDING.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51490 ✓ D.51490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 17 WARD)

2-FULL NAME Russell Chase

(a) RESIDENCE. NO. 920 Elm Place ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	B.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		14		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Daniel Easton

(Address) 966 Cross

15 MAR 5 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1921, to Feb 3, 1921, that I last saw h[illegible] alive on Feb 3, 1921, and that death occurred, on the date stated above, at 10.45 p. m.

The CAUSE OF DEATH* was as follows:

Tetany

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) ..... M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	March 6 1921
20 UNDERTAKER Daniel Easton	ADDRESS 966 Cross

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51491 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 20.51491

CERTIFICATE OF DEATH. 151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 E Hamburg ST. 24 WARD)

2-FULL NAME Charlie Wheatley

(a) RESIDENCE. No. 312 E. Hamburg ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 2 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (Child)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Charlie C Wheatley

11 BIRTHPLACE OF FATHER (city or town) Cambridge
(State or country) Md

12 MAIDEN NAME OF MOTHER Ella E Pontime

13 BIRTHPLACE OF MOTHER (city or town) Denton
(State or country) Md

14 Informant Mr Charlie C Wheatley
(Address) 312 E Hamburg St

15 Filed MAR 10 1921, 19 Robert P. Lattimore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 2, 19 21, to March 4, 19 21, that I last saw h alive on March 4, 19 21, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bron

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C M Radcliffe, M. D.

March 19 21 (Address) 1279 Bellevue St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK	MAR 1921

20 UNDERTAKER JOHN F. DENNY ADDRESS 710 LIGHT ST.

MARGIN—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51492

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51492

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 Jadesan ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Franklin Grover

(a) RESIDENCE. No. 1741 Jadesan ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Robert Grover

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Kate Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Robt Grover
(Address) 1741 Jadesan st.

15 Filed MAR 5 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4/21 19

17 I HEREBY CERTIFY, That I attended deceased from 3/16/21, 19..., to 3/4/21, 19..., that I last saw h— alive on 3/4/21, 19..., and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Philip B. Taule M. D.

3/6/21 19 (Address) 4432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	3/ 19
20 UNDERTAKER Wm J. E. Evans Son	ADDRESS 1728 Chl

MARGIN MUST BE KEPT CLEAR

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51493 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51493

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 S. Paca st ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. W. Born

(a) RESIDENCE. No. 435 S. Paca st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of Louisa. H. Born

6 DATE OF BIRTH (month, day, and year) Nov 15 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 803

(b) General nature of industry, business, or establishment in which employed (or employer) in Business for

(c) Name of employer Himself

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER August Born

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germy

12 MAIDEN NAME OF MOTHER Caroline Heingerlen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germy

14 Informant Louisa H. Born
(Address) 435 S. Paca

15 Filed ....., 19 .....

Robert P. Harrison, Registrar

MAR5 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to Mar. 4, 1921,

that I last saw him alive on March 4, 1921,

and that death occurred, on the date stated above, at 6 30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of 20

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J M Elliott, M. D.

Mar 5 21 (Address) 621 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	March 7 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	217 S. Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51494

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51494

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hawkins Point, Md 120 REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Robinson

(a) RESIDENCE. NO. Hawkins Point Road ST., 25 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, ~~widowed or divorced~~ HUSBAND of (or) WIFE of George Robinson

6 DATE OF BIRTH (month, day, and year) ? 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Acy Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) George Robinson

15 Filed ....., 19 Robert P. Harrison, Registrar

MAR 5 - 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 19 21

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1920 to March 1, 19 21 that I last saw her alive on Feb 28 19 21 and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) General Dropsy

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis J. Hoska, M. D.

, 19 (Address) 929 Fayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Molly Neck A.A.Co. Md.	Mar 6 19 21
20 UNDERTAKER Joseph A Farrell	ADDRESS 2319 Division

N. B.—WRITE PLAINLY, WITH UNFADING INK. ... should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ... is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51495

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51495

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ew City Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Jones

(a) RESIDENCE. NO. 244 S. Bethel St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Dennis Jones

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Gordon

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

Filed MAR 5 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 5, 19 21. to March 4, 19 21.
that I last saw him alive on March 4, 19 21.
and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X-ray evidence

(Signed) V. K. Herman, M. D.

3/4/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	March 6th 1921
20 UNDERTAKER Joseph A. Farrell	ADDRESS 1429 Druid

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS—should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 51496

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51496

CERTIFICATE OF DEATH.

92-010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.; 28 W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Hickey

(a) RESIDENCE. No. Washington D.C. ST., ... WARD.

(Usual place of abode) (If not in limits of a city, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC -

PARENTS

10 NAME OF FATHER Laurence Hicky -

11 BIRTHPLACE OF FATHER (city or town) Co Kerry (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McCarthy

13 BIRTHPLACE OF MOTHER (city or town) Co. Kerry (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md

15 FILED MAR 6 - 1921 ROBERT B. BRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1900, 19..., to March 5, 1921, that I last saw him alive on March 5, 1921, and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar) Post La Grippe(?)

abt (duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Feeble minded -

for abt (duration) 35 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Washington D.C -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington, D. C.	3/5 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51497

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51497

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH 113 E. Mulberry St.

CITY OF BALTIMORE: (No. 113 ST.: E. Mulberry WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose McCollough

(a) RESIDENCE. No. 113 E. Mulberry ST.. WARD. (If nonresident give city or town and State) South Carolina

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Linton.

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook Cook 071

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Laurens S.C.

PARENTS

10 NAME OF FATHER Jacob Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rose McCollough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Laurens S.C.

14 Informant George Young (Address) 113 E. Mulberry St.

15 Filed MAR 6 - 1921 19 ..... Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to March 4, 1921, that I last saw her alive on March 4, 1921, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis Chron Nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) W. J. Barfield, M. D.

3/4, 1921 (Address) 710 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemy

DATE OF BURIAL March 7 19

20 UNDERTAKER Felix B Pyb

ADDRESS 102 E Mulberry

MARGIN RESERVED FOR REGISTRAR'S STAMP

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful, supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D 51498

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N. Greene ST.; 4th WARD) REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Kapalnus or King

(Residence in Baltimore: No. 212 N. Greene St.; 30 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	White	Married

6-DATE OF BIRTH, July (Month) 30 (Day), 1887 (Year)

7-AGE, 33 yrs. 7 mos. 3 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 037
(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper

9-BIRTHPLACE, (State or Country), New York N.Y.

PARENTS.

10-NAME OF FATHER, Peter Litvinas

11-BIRTHPLACE OF FATHER (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER Eva. Senkus.

13-BIRTHPLACE OF MOTHER (State or Country), Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter King

(Address) 212 N. Greene St.

15-MAR 6 - 1921 Filed ....., 191... ROBERT E KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 3 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2 1921, to March 3 1921, that I saw h[illegible] alive on March 3 1921, and that death occurred, on the date stated above, at 10 30 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

.... (Duration) .... yrs. .... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

.... (Duration) 2 yrs. .... mos. .... ds.

(Signed) John A. Skladowsky M. D.

3/4/, 21, (Address) 638 Columbus Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 212 N. Greene St

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, March 7, 1921

20-UNDERTAKER John Grebliauckas ADDRESS 725 S. Eden St

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A

Spec.—6-9-19—H. P. Co.—1000 Blks.

251499

HEALTH DEPARTMENT—CITY OF BALTIMORE

251499

CERTIFICATE OF DEATH.

9-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanore Elkund

(a) RESIDENCE. NO. 417 Twelfth ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12-1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Elkund

11 BIRTHPLACE OF FATHER (city or town) Laurel (State or country) Md.

12 MAIDEN NAME OF MOTHER Florence Cava

13 BIRTHPLACE OF MOTHER (city or town) Alicante (State or country) Italy

14 Informant Daniel Elkund (Address) 417 Twelfth St.

15 MAR 6 - 1921 ROBERT J. BRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to March 5, 1921, that I last saw her alive on March 5, 1921, and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal. 4 ds.

(duration) — yrs. — mos.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None - culture neg.

(Signed) B. Macgowan, M. D.

, 19 (Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem.

DATE OF BURIAL March 6 1921

20 UNDERTAKER Lilly and Zeller.

ADDRESS 403 S. Wolfe

MARGIN RESERVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' information should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

051500

HEALTH DEPARTMENT—CITY OF BALTIMORE

051500

CERTIFICATE OF DEATH.

97-054

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 748 W. Franklin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Walker

(Residence in Baltimore: No. 748 W. Franklin St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ? (Month) ? (Day), 189? (Year)

7-AGE. 30 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... 270

9-BIRTHPLACE, (State or Country), Back Cey

PARENTS.

10-NAME OF FATHER, J. H. Walker

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Nugent

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Walker

(Address) 748 W. Franklin

15- Filed MAR 6 - 1921 191.....

BOREAU OF VITAL STATISTICS

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1920, to March 3 1921, that I saw her alive on March 3 1921, and that death occurred, on the date stated above, at 2.30 Pm

The CAUSE OF DEATH* was as follows:

Primary Anemia

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(Duration) yrs. mos. 4 ds.

(Signed) J. McPherson M. D.

3/ ....., 191... (Address) 73 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Mar 6 1921

20-UNDERTAKER Samuel Kemp & Wm Blake ADDRESS 578

WRITE PLAINLY, WITH UNFADING INK—THIS IS LAW.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is very CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D51501 HEALTH DEPARTMENT—CITY OF BALTIMORE D51501

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1109 Russell St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Manokey. (C)

(Residence in Baltimore: No. 1109 Russell St. St.: 23 yrs., ---- mos., ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	Colored.	Widower.

6-DATE OF BIRTH. ....Do not know...., 1 .....
(Month) (Day) (Year)

7-AGE, ...49....yrs. ----mos. ----ds. If LESS than 1 dy, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Laborer.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), A. A. Co. Md.

PARENTS.

10-NAME OF FATHER, Charles Manokey. (C)

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Mary Thomas. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E. Williams. (C)

(Address) 443 E. 23rd. St.

15- MAR 8-1921 BURTON L KRAUTER

Filed ..... 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 4th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....inquiry.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....inquiry.... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Chronic Interstitial Nephritis.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Einhardt M. D.
(Coroner.)

March 5, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Mar. 6., 1921
20-UNDERTAKER Samuel P. Hensley	ADDRESS 578 N Bro[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51502

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH mercy hospital ✓ 124

CITY OF BALTIMORE: (No. Baltimore md ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Smith

(a) RESIDENCE. NO. Glenelg P O - Howard Co - md ST., WARD. Glenwood Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Smith

6 DATE OF BIRTH (month, day, and year) Feb 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife (37)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) John Saunders Howard Co Md

15 Filed MAR 6 - 1921 ROBERT B. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to March 4, 1921, that I last saw h[illegible] alive on March 4, 1921, and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) 6 pertus for 6 years Hysterectomy for multiple fibroids

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of 2/23/21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J W Martindale M. D

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bush Park Cemetery Glenwood Howard Co Md — DATE OF BURIAL Mch 7 1921

20 UNDERTAKER John W Toadvine — ADDRESS 142 N Steel St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51503

D51503

CERTIFICATE OF DEATH.

1920

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 S Charles St ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John P Miller

(Residence in Baltimore: No. Same 815 S Charles St ST.; 1 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, July (Month) 29 (Day) 1852 (Year)

7-AGE, 68 yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Dyer
(b) General nature of industry, business, or establishment in which employed (or employer) do

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Casper Miller

11-BIRTHPLACE OF FATHER (State or Country), Germy

12-MAIDEN NAME OF MOTHER Wehrman

13-BIRTHPLACE OF MOTHER (State or Country), Germy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Fred. Miller

(Address) 1040 N. Broadway

15-Filed MAR 6 - 1921, 191.... [illegible] Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 3 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July-1 1920, to March 3 1921, that I saw h..... alive on March 3 1921, and that death occurred, on the date stated above, at 6.15 m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Marion O Smith M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mount Olivet Cem | DATE OF BURIAL, March 7, 1921

20-UNDERTAKER E Schulman & Son | ADDRESS 1039 Pennsylvania Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51504 HEALTH DEPARTMENT—CITY OF BALTIMORE D51504

CERTIFICATE OF DEATH. 78

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 22 WARD)

2-FULL NAME Regina Walters

(a) RESIDENCE. NO. 535 S Paca St ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25-1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Adolphus Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mississippi

12 MAIDEN NAME OF MOTHER Annie Slade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record (Address) Johns Hopkins Hosp.

15 MAR 6 - 1921 ROBERT J. BRAUER Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4-1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 28, 1921, to March 4, 1921, that I last saw h-r alive on March 4, 1921, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Acute endocarditis

Chorea

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chorea.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? yes Date of 3-1-21

Was there an autopsy? yes.

What test confirmed diagnosis? Microscopic & bacteriological

(Signed) E. M. Brough, M. D.

3-5, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Project Cem. Lawsend Md

DATE OF BURIAL March 7 1921

20 UNDERTAKER J. Ahrens & Co

ADDRESS 221 N. Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED

Parynis

D 51505

Dec. 6-9-19—H. P. Co.—1000 Blks.

D 51505 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 241 S Regester ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wicenty Parynis

(a) RESIDENCE. NO. 241 S Regester ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Karolina

6 DATE OF BIRTH (month, day, and year) June 30 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Kunkel wagon ca

(b) General nature of industry, business, or establishment in which employed (or employer) 007

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Aleksander Parynis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josepha unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Karolina Parynis (Address) 241 S Regester

15 Filed MAR 6 - 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb - 28, 1921, to March 5, 1921, that I last saw h— alive on March 4, 1921, and that death occurred, on the date stated above, at 550 A m.

The CAUSE OF DEATH* was as follows:

Pleur. Pneumonia - Acute -

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Contract Failure -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? name

(Signed) Mark Brauer, M. D.

5/3/1921 (Address) 125 N Broadway -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 7 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

· MARGIN RESERVED FOR BINDING ·

251506 HEALTH DEPARTMENT—CITY OF BALTIMORE 251506

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. #3 ST.: Elevator Tower WARD) 17

2-FULL NAME Wasil Gilsluk

(Residence in Baltimore: No. 1115 Hull St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St., 10 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Unknown, / (Month) (Day) (Year)

7-AGE, 36 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer): Steamship

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Silvester

(Address) 1115 Hull St.

15- Filed MAR 6 — 1921 191.... BOEHLER & KRAUTER Burial Permit Register.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 4, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Killed by fall at Elevator No 3 - while at work

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. H. Driscoll M. D. (Coroner)

3/7, 1921 (Address) 1800 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, 1st. Evangelical. DATE OF BURIAL, Mar 7, 1921

20-UNDERTAKER Wm Fiackowski ADDRESS Eastern

Spec.—6-9-19—H. P. Co.—1000 Bks.

051507

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

051507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madora Purvey

(a) RESIDENCE. NO. 632 W. Montgomery st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	~~Female~~ Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lizzie Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records M.T.H.

15 Filed MAR 6 - 1921 19 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1921, to March 3, 1921, that I last saw her alive on March 3, 1921, and that death occurred, on the date stated above, at 6.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) L. H. Fahnestock, M. D.

3-4-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3/6 1921
20 UNDERTAKER	ADDRESS
Thos Gorter & Sons	Govans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D 51508

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 Eastern Ave ST.: 7 WARD)

2-FULL NAME Anna Loukota.

(a) RESIDENCE. No. 2015 Eastern ave ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Joseph Loukota.

6 DATE OF BIRTH (month, day, and year) April 1st 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Francis E Weber (Daughter)
(Address) 2015 Eastern Ave.

15 Filed MAR 6 - 1921, 19.. ROBERT I KRAUSE Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3rd 1921

I HEREBY CERTIFY, That I attended deceased from March 3, 19 21, to March 3, 19 21, that I last saw h[illegible] alive on March 3, 19 21, and that death occurred, on the date stated above, at 3 45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
Grippe

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

I Signed: William J Rauch M. D.
19 (Address) 101 N Regester St

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill Cemetery — DATE OF BURIAL: March 6th 1921

20 UNDERTAKER: Lilly - Zeiler — ADDRESS: 400 S. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51509

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 17 S. Hare ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia H. Schimminger

(a) RESIDENCE. NO. 17 S. Hare ST.. 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. E. Schimminger

6 DATE OF BIRTH (month, day, and year) May 14 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Jung

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Bolte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Jos. E. Schimminger 17 S. Hare St.

15 Filed MAR 6 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5 1920, to Mar 4 1921, that I last saw her alive on Mar 4 1921, and that death occurred, on the date stated above, at 3.40 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? None of

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) B. H. Kelly, M. D.

, 19 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthew's Cemetery	March 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 4038 Woodlawn

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should be stated EXACTLY. PHYSICIANS should be careful supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful supplied. AGE should be mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51510

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51510

CERTIFICATE OF DEATH.

10-089

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Spruce ST. 17 WARD)

2-FULL NAME Caroline Creagh.

(a) RESIDENCE. NO. 2006 Spruce ST., 2 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Peter Creagh

6 DATE OF BIRTH (month, day, and year) June 3rd 1837

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Fredericks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Beck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Finches (Address) 2006 Spruce St.

15 Filed MAR 6 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1921, to March 4, 1921, that I last saw h[illegible] alive on March 2, 1921, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

following Influenza

CONTRIBUTORY (Secondary) old age (duration) yrs. mos. 7 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. T. Hardy M. D.

, 19 (Address) 1202 N Edm St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Mch 8th 1921
20 UNDERTAKER	ADDRESS
Lilly + Julien	403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN MUST NOT BE USED. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D51511

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51511

CERTIFICATE OF DEATH.

REGISTERED No. C 15

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1042 Whetstone ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Landsdorne

(Residence in Baltimore: No. 1042 Whetstone St.; ....yrs., ...mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	Col.	Single

6-DATE OF BIRTH, March 4th, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), md.

PARENTS.

10-NAME OF FATHER, Henry Landsdorne

11-BIRTHPLACE OF FATHER (State or Country), Jamaica B.W.I.

12-MAIDEN NAME OF MOTHER Rosa Reed

13-BIRTHPLACE OF MOTHER (State or Country), Jamaica B.W.I.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Landsdorne

(Address) 1042 Whetstone St

15- Filed MAR 6 - 1921, 191... ROBERT F. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3/6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3/4, 191..., to 3/6, 1921, that I saw her alive on 3/5, 1921, and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from umbilical cord (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Clipped ligatures (Duration) ....yrs. ....mos. ....ds.

(Signed) Burnham Brawley M. D.

3/6, 191... (Address) 908 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Mar 6..., 1921

20-UNDERTAKER Brantner & Tiedland — ADDRESS 1140 N Schroeder St

N.B.—Every item of information should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51512

CERTIFICATE OF DEATH. 74-041

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 11 Jenkins Hospital St. 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Hopkins

(a) RESIDENCE. No. Annapolis St. Med WARD. Easton Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Sing'l

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Hy P Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alpena Jump

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry Hopkins

(Address) Annapolis

15 Filed MAR 6 - 1921 ROBERT N. BEAUTIEN Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1921

17 I HEREBY CERTIFY, That I attended deceased from December 3 1920 to March 5 1921

that I last saw h alive on March 5 1921

and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Schwenck M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton Maryland	Mar 7 1921
20 UNDERTAKER W J Lickner & Sons	ADDRESS Northw Penna ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should give information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51513 HEALTH DEPARTMENT—CITY OF BALTIMORE D51513

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hosp. St. 26 44 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R. Cadwallader

(a) RESIDENCE. No. New City Hosp. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer) Fisherman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - Md.

PARENTS

10 NAME OF FATHER Abe Cadwallader

11 BIRTHPLACE OF FATHER (city or town) Penna (State or country)

12 MAIDEN NAME OF MOTHER Mary Cadwallader

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant New City Hosp Records (Address)

15 Filed MAR 6 - 1921 ROBERT A KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 5 - 1921

17 I HEREBY CERTIFY, That I attended deceased from 1 - 19, 1920, to 3 - 5, 1921, that I last saw him alive on 3 - 5 - , 1921, and that death occurred, on the date stated above, at 10: a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ear

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

Sec. Anemia (duration) 1 yrs. mos. 3 ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) F. A. Holden, M. D.

3-5, 1921 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL 3/7 1921

20 UNDERTAKER William Cook ADDRESS 502 E Lex St

N. B.—WRITE PLAINLY, WITH UNFADING INK—MARGIN NOT TO BE SOILED OR DAMAGED. PHYSICIAN'S mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51514

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51514

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2929 Wallbrook Ave ST.: 15 WARD)

2-FULL NAME Elizabeth J. Somerville

(a) RESIDENCE. NO. 2929 Wallbrook Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced (or) WIFE of the late Wm. H. Somerville

6 DATE OF BIRTH (month, day, and year) Feb 28-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	-	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jessie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ida L. Somerville (Address) 2929 Wallbrook Ave

15 Filed MAR 6 - 1921 ROBERT I. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921.

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Mar 4, 1921, that I last saw her alive on Mar 4, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Cardiac Dilitation

CONTRIBUTORY (Secondary) Chr Mitral Regurg (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Chas A Clark M. D.

Mch 5 1921 (Address) 1502 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL March 7 1921

ADDRESS 503 S. Wolfe Street

20 UNDERTAKER William Cook

MARGIN RESERVED FOR RECORDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. Name of employer should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be given on back of certificates. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D51515 HEALTH DEPARTMENT—CITY OF BALTIMORE D51515

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 W. North St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret D. Kofler

(Residence in Baltimore: No. 932 W. North Ave St.; 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 11th, 1880 (Month) (Day) (Year)

7-AGE, 40 yrs. 11 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Philadelphia Pa.

PARENTS.

10-NAME OF FATHER, John B. Hogan

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia Pa

12-MAIDEN NAME OF MOTHER Russell Wieland

13-BIRTHPLACE OF MOTHER (State or Country), Philadelphia, Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. Kofler

(Address) 932 W. North Ave

15- Filed MAR 6 - 1921, 191... ROBERT J. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 5th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5th 1920, to March 5th 1921, that I saw her alive on March 3rd 1921, and that death occurred, on the date stated above, at 4:40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of 9th 10th & 11th Vertebrae with Extensions

(Duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Keown M. D.

Mch 5th, 1921 (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, March 7th, 1921

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Baltimore St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51516 ✓ D 51516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 Dolphin ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter J. Parker

(a) RESIDENCE. No. 329 Dolphin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine J. Parker

6 DATE OF BIRTH (month, day, and year) Feb 16, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Peter J. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Geo H Parker

(Address) 329 Dolphin St.

15 Filed MAR 6 - 1921 ROBERT P. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1921, to Mar 4, 1921, that I last saw him alive on Mar 4, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Bellevue, M. D.

3/5, 1921 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Woodlawn — DATE OF BURIAL Mar 7 1921

20 UNDERTAKER Geo W Little — ADDRESS 2700 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D51517

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51517

CERTIFICATE OF DEATH.

10-084

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1307 N. Eden ST.: 8 WARD)

2-FULL NAME Amanda C. Stouffer

(a) RESIDENCE. NO. 1307 N. Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Peter B. Stouffer ~~Deceased~~

6 DATE OF BIRTH (month, day, and year) ~~September~~ 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co (State or country) Md

PARENTS

10 NAME OF FATHER Benjamin F Catton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sallie Nichols

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co (State or country) Md

14 Informant Mrs Annie C Prins

(Address) 1307 N. Eden st

15 FILED MAR 6 - 1921 ROBERT J. ABBOTT Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1921, to Mch 5, 1921, that I last saw h 2(alive on Mch 5, 1921, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Bronchitis and influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm T Watson, M. D.

Mch 5. 1921 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Episcopal Cemetery Frederick Co Md	Mar 7 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WHITE PLAINLY, WITH UNFADING INK—THIS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D51518

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51518

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 8 WARD) 1865 REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Ott.

(Residence in Baltimore: No. 1968 Belair Road. St.; 77c yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 31st, 1889
(Month) (Day) (Year)

7-AGE, 31 yrs. 4 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Ott

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Sommers

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna M Ott

(Address) 1952 Bel air Road

15- ROBERT J. KRAUTER

Filed MAR 6 — 1921 191... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Accident
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. ds.

(Signed) Geo Rhode M. D.
(Coroner.)

3/5/1921 191... (Address) 143 N Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Country

DATE OF BURIAL, Mar 8th, 1921

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

Globe Ship Bldg Co.
Butte & Bay

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urænia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *scptichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage*,	*Meningitis*,	*Phlebitis*,
Cellulitis,	*Gangrene*,	*Miscarriage*,	*Pyæmia*,
Childbirth,	*Gastritis*,	*Necrosis*,	*Septicæmia*,
Convulsions,	*Erysipelas*,	*Peritonitis*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Macauley. ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51519 HEALTH DEPARTMENT—CITY OF BALTIMORE D51519

CERTIFICATE OF DEATH. 50-092

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 N Chester ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret MacCauley.

(a) RESIDENCE. No. 1805 N. Chester ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas MacCauley

6 DATE OF BIRTH (month, day, and year) Dec 31 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Chas Macauley (Address) 1805 N Chester pl

15 MAR 6 - 1921 ROBERT J. BRADDOCK Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1921, to Mar 4, 1921, that I last saw her alive on Mar 4, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) John W. Sanderson M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	3/7 1921
20 UNDERTAKER Geo A Farley	ADDRESS Fulton & Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D51520 HEALTH DEPARTMENT—CITY OF BALTIMORE D51520

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1017 S. East Ave ST. 26 WARD) REGISTERED No. C 151

2-FULL NAME Dorothy Zaleski

(Residence in Baltimore: No. 1017 So. East Ave St.; yrs., 4 mos. 11 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH October 23, 1920
(Month) (Day) (Year)

7-AGE, yrs. 4 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X X
(b) General nature of industry, business, or establishment in which employed (or employer) X X

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Alexander

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Josephine Barszek

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. F. Sadowski

(Address) 705 S. Ann st

15- MAR 6 - 1921 BOYER & KRAUTER

Filed ....., 191.. Burial Permit Issued
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH March 5, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Ryan Krieg M. D.
(Coroner)

3/7, 1921. (Address) 1400 Aliceanna

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary Cem.	March 7, 1921.
20-UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann St

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of date is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ratz.

D51521 HEALTH DEPARTMENT—CITY OF BALTIMORE D51521

CERTIFICATE OF DEATH. 60

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1644 Abbott st ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonia Ratz

(a) RESIDENCE. No. 1644 Abbott ST.....WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Ozsely Nozzi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mrs Anna Faller

(Address) 1644 abbott st

Filed MAR 6-1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to Mar 4, 1921, that I last saw h alive on Mar 3, 1921, and that death occurred, on the date stated above, at 7 Ao m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Valentine, M. D.

Mar 5, 1921 (Address) #2 n Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Mar 7 1921

20 UNDERTAKER Robt J Turner Sole ADDRESS 1424 Pratt

DEATH in plain terms, so that it may be properly classified. Use no abbreviations or terms not generally understood. Every question must be answered, or a reason given for the omission. Typewriting is preferred, but if the certificate is written, it must be in ink. Please write plainly. Use only Roman letters. Do not roll. Physicians and others are requested to read carefully the instructions on back of certificates. This is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51522

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51522

154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1627 Ensor (St.) (Ward) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME R. Lorenz Lasinski

(a) RESIDENCE. (No.) 1627 Ensor St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred about 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? about 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of) the late Antonia Lasinski

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad Employe

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Margaret M. Trexler

(Address) 1627 Ensor St.

15 Filed MAR 6 - 1921 19 ROBERT A. LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1921, to Mar. 6th, 1921, that I last saw him alive on Mar. 5th, 1921, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Influenza & old age

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. H. Magruder, M. D.

, 19 (Address) 14 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 8 1921
20 UNDERTAKER	ADDRESS
Henry Hoch & Son	130 E Eager

INSTRUCTIONS. Please write plainly, so that it may be properly examined. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 51523 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51523

CERTIFICATE OF DEATH.

REGISTERED NO. 579

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1634 Gilmor ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza C. Rheinhart

(a) RESIDENCE. NO. 1634 Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widow of John H. Rheinhart

6 DATE OF BIRTH (month, day, and year) Nov. 24 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home, died

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Rickard.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Maria Appleby.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Georgianna Barger
(Address) 1634 N. Gilmor St. Balto. City

15 FILED MAR 7 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1921.

17 I HEREBY CERTIFY, That I attended deceased from March 2. 1921. to March 6 1921.
that I last saw her alive on March 6 . 1921.
and that death occurred, on the date stated above, at 1.10 P. m.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. the mos. + ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart. Anaemia,
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Oedema

(Signed) Charles E. Clark, M. D.

3-6. 1921 (Address) 1306 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Messiah Cemetery, Carroll Co. Md.	March 9. 1921
20 UNDERTAKER	ADDRESS
C. M. Watts.	Winfield Md.

Make entries on this certificate in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 51524

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51524

CERTIFICATE OF DEATH.

64

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2753 Tivoly Ave. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Mueller

(Residence in Baltimore: No. 2753 Tivoly Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, Oct. (Month) ..... (Day), 1863 (Year)

7-AGE,	If LESS than 1 day,
58 yrs. ....mos. ....ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hotel Cook
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Andrew Mueller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Do not Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Denhardt

(Address) 616 W Lexington

15-Filed MAR 7 - 1921 ROBERT I KRAUTER Burial Permit Clerk. 191....

N.B. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to March 5 1921, that I saw him alive on March 4th 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Haemaplegia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Ex Insufficiency

(Duration) ....yrs. ....mos. ....ds.

(Signed) Harry Goldberg M.D.

3/6/, 1921. (Address) 2210 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
New Cathedral	3/7/, 191...
20-UNDERTAKER, John J Tobey & Sons	ADDRESS 131 S Eutaw St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51525

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51525

CERTIFICATE OF DEATH.

43

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 Evesham Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Elizabeth Richmond

(Residence in Baltimore: No. 603 Evesham Ave, Govans Md. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 30 (Day) 1844 (Year)

7-AGE, 76 yrs. 9 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired Educator
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Richmond

11-BIRTHPLACE OF FATHER (State or Country), France

12-MAIDEN NAME OF MOTHER Mary A Seesnup

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Martha A Richmond

(Address) 603 Evesham Ave

15- MAR 7 - 1921 ROBERT J KRAUTER

Filed ....., 191.... Burial ..... Registrar.

N. B. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 4 (Month) (Day) 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1920, to Mar 4 1921, that I saw her alive on Mar 4 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast with metastases

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mildred A Clough M. D.

Mar. 4, 1921. (Address) 24 E Eager St. Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, MAR 7 - 1921

20-UNDERTAKER Henry W Jenkins & Son

ADDRESS Orchard & McCulloh Sts

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51526

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1 Russell St. Mt Winans (WARD) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Arnold

(a) RESIDENCE. NO. 1 Russell St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Col	widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Elbert Arnold

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework none

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Fielding Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Rose Arnold Mt Winans

15 MAR 7 - 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1921, to March 4, 1921, that I last saw her alive on March 4, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine

(Signed) Raymond Blume, M. D.

, 19 (Address) Lakeland.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
in Remington Va	March 7 1921
20 UNDERTAKER. Jnrs Robert A Elliott	ADDRESS 1725 Lakland Av

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE should be carefully supplied, so that it may be properly classified. Every nation should be carefully supplied, so that it may be properly classified. Every nation should be carefully supplied, so that it may be properly classified. DATE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51527

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital, ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Jennings

(a) RESIDENCE. No. 952 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 18, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant E. J. Jennings

(Address) 952 Hollins St

15 MAR 7 - 1921 ROBERT J. FRAZIER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to Mar 6, 1921, that I last saw h~~e~~r alive on Mar 5, 1921, and that death occurred, on the date stated above, at 5.15 A m.

The CAUSE OF DEATH* was as follows:

Rupture of a cerebral vessel -

(duration) yrs. 6 wks ds.

CONTRIBUTORY (Secondary) Oedema of Lungs (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs.

(Signed) Edw. L. Kaufman M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem

DATE OF BURIAL 3/8/ 1921

20 UNDERTAKER John Howard & Son

ADDRESS 908 Hollins

mation should be carefully supplied, so that it may be properly classified. Data CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D515 28 HEALTH DEPARTMENT—CITY OF BALTIMORE D515 28

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bay View Hospital 37 REGISTERED NO.....

CITY OF BALTIMORE: NO. ..... ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Wicks

(a) RESIDENCE. NO. 714 Druid Hill Ave ST. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 ~~Single, Married~~, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years: 50. Months: ..... Days: ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Maryland. Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Do.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do. Unknown

14 Informant: Hospital Record (Address) .....

15 MAR 7 - 1921 ROBERT F. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1921, to March 5, 1921, that I last saw h.. alive on March 4, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Senile Cataract

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Serological

(Signed) H. F. Smith M. D.

3/5/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from [illegible] Causes, state (1) Means and Nature of Injury, and (2) whether [illegible]ental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mch 8 1921
20 UNDERTAKER	ADDRESS
John H. Spading	1412 Eutaw St

mation should be carefully written in plain terms, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

2051529

2051529

CERTIFICATE OF DEATH.

119

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2722 Huntington Ave ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Scott

(a) RESIDENCE. NO. 2722 Huntington Ave ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Maria W Scott

6 DATE OF BIRTH (month, day, and year) Oct 6 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R. R. Police

(b) General nature of industry, business, or establishment in which employed (or employer) P.R.R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Edw S Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fannie Justice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Mary Scott

(Address) 2722 Huntingdon Ave

15 MAR 7 - 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1921, to March 3, 1921, that I last saw h[illegible] alive on March 3, 1921, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical.

(Signed) Edward V Cookelman, M. D.

, 19 (Address) 24 N Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Hampden	Mar 5 1921

20 UNDERTAKER T S Marshall ADDRESS 3539 Fall Rd

mation should be entered in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51530 HEALTH DEPARTMENT—CITY OF BALTIMORE D51530

CERTIFICATE OF DEATH. 6 154

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Amelia Babcock.

(a) RESIDENCE. No. 6 Church Home & Inf. ST... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug-28-1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John Babcock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Massachusetts.

12 MAIDEN NAME OF MOTHER Maria Cass.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Connecticut

14 Informant (Address) E. K. Rogers 722 Reservoir St.

15 Filed MAR 7 - 1921 ROBERT E. CRAWFORD Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1920. to Mar. 6 1921.

that I last saw her alive on Mar. 5 1920.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Undetermined; only cause determinable without autopsy was senility.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Neff Grauff, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Mch 8 1921

20 UNDERTAKER H. E. Hughel ADDRESS 1st & Broadway

mation SHOULD BE GIVEN. Use typewriter or write in ink. Do not abbreviate. Use full names of persons, streets and localities. Be careful and exact in answering every question. Where there is no entry to be made, write "None" or "Unknown" so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51531

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Wheat

(a) RESIDENCE. NO. 3017 Cedar Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2 - 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert Wheat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ethel Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. Hite Reeves
(Address)

15 Filed MAR 7 - 1921 ROBERT I. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 - 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 25, 1921, to March 6, 1921, that I last saw her alive on March 6, 1921, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchopneumonia

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Horton Casparis, M. D.

3-6, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	March 7 1921

20 UNDERTAKER Chenowith & Son ADDRESS 1600 Chestnut Ave

INFORMATION should be given in plain terms, so that it may be understood by those not familiar with technical terms. CAUSE OF DEATH in plain terms, so that it may be understood by those not familiar with technical terms. See instructions on back of certificates.

D51532 HEALTH DEPARTMENT—CITY OF BALTIMORE D51532

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1442 Harford Ave. WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary V. Cook

(Residence in Baltimore: No. 1442 Harford Ave St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. July (Month) 20 (Day), 1843 (Year)

7-AGE, 77 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): Dead

9-BIRTHPLACE, (State or Country), Ky

PARENTS.

10-NAME OF FATHER, William Meredith

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER E. Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ella Vance

(Address) 1442 Harford Ave

15- ROBERT J. KRAUTER

Filed MAR 7 - 1921 191 Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 5 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] (Coroner.) M. D.

Mar 6, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	Mar 8 1921
20-UNDERTAKER	ADDRESS
William Cook	502 E Nor.

N. B.—Every item of information should be carefully sought for, as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificate.

Mr Forster 6-/Sale.

D51533 HEALTH DEPARTMENT--CITY OF BALTIMORE D51533

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Washington Road St.: 35 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Michael

(Residence in Baltimore: No. Washington Road St.: 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: January (Month) 2 (Day), 1840 (Year)

7 AGE: 81 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: General Hauling Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 86

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Michael

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H Michael

(Address) 9 Gorman ave

15 Filed MAR 7 - 1921 ROBERT A KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 6 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feby 21, 1921, to March 6 1921, that I saw h[e] alive on March 4, 1921, and that death occurred, on the date stated above, at 5-20A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 3 mos. ds

Contributory (SECONDARY) same

(Duration) yrs. 3 mos. ds.

(Signed) Geo L McKeller M. D.

March 6, 1921 (Address) Maryland Casualty

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery

DATE OF BURIAL: 3/8, 1921

20 UNDERTAKER: Heeman Cook

ADDRESS: 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D51534 HEALTH DEPARTMENT—CITY OF BALTIMORE D51534

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 390 E 31 St ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S Maney

(a) RESIDENCE. No. 390 E 31 St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J May E Maney

6 DATE OF BIRTH (month, day, and year): Oct 9/1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77 ~~76~~	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Jersey

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: George N Walker (Address) 3978 Gist St

15 Filed MAR 7 - 1921 ROBERT A KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to March 5, 1921, that I last saw him alive on March 4, 1921, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis About (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis About (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Reinhardt M. D.

3-6-21 (Address) 1100 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	March 8 1921

20 UNDERTAKER: Wm Lochner & Natta ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D51535 HEALTH DEPARTMENT—CITY OF BALTIMORE D51535

CERTIFICATE OF DEATH.

REGISTERED No. C 12742

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 E. Twentieth ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H Bucher.

(Residence in Baltimore: No. 412 E. Twentieth St.; 77 yrs., 7 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, July (Month) 10 (Day), 1843 (Year)

7-AGE, 77 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Abraham Bucher.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Don't Know.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Bucher

(Address) Madison Av.

15- ROBERT J. REAUTER

FILED MAR 7 - 1921 191.. Burial Permit Clerk

Registrar.

CAUSE OF DEATH in plain terms. If unknown, state. It is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 5th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21 1921, to Mch 5 1921, that I saw h[illegible] alive on Mch 5 1921, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor

probable cause of blindness 13 yrs ago (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hunt Forsythe, M. D.

Mch 5, 1921. (Address) 424 E. North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Johns Waverly

DATE OF BURIAL, Mar. 7, 1921

20-UNDERTAKER H. C. Wiedefeld & Greenmount

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51536 HEALTH DEPARTMENT—CITY OF BALTIMORE D51536

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Barlow.

(a) RESIDENCE. No. Preston & Valley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio, U.S.A.

PARENTS

10 NAME OF FATHER Thomas Barlow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susanna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant

(Address) Sister Florence

MAR 7 - 1921

ROBERT J. KRAUSER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1921

17

I HEREBY CERTIFY, That I attended deceased from No record, 19, to, 19,

that I last saw h[illegible] alive on Feby 27, 1921,

and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

1 (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Davis, M. D.

March 6, 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Mar 7 1921

20 UNDERTAKER	ADDRESS
H.C. Wiedefeld	914 Greenmt Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Do not use abbreviations. Do not write "Old Age" or "Natural Causes" as CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 5 1 5 37

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 5 1 5 37

CERTIFICATE OF DEATH.

392

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Watson ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Page Faggins

(a) RESIDENCE. NO. 1005 Watson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs mos. ds. How long in U. S., if of foreign birth? 4 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Henry Faggins

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Farmville Virginia

PARENTS

10 NAME OF FATHER Page Pryor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Farmville Virginia

12 MAIDEN NAME OF MOTHER Eliza Venerable

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Farmville Virginia

14 Informant Henry Faggins

(Address) 1005 Watson

15 MAR 7 - 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17

I HEREBY CERTIFY, That I attended deceased ~~from~~

On March 4 1921. ~~—— —— ——~~

that I last saw her alive on March 4 1921.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 14 dys

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

, 19 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Farmville Va	March 19 21
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51538

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405-Poplar Grove St.; 16 Ward)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Esther Johnson

(a) RESIDENCE. No. 1405-Poplar Grove St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Robt. M. Johnson

6 DATE OF BIRTH (month, day, and year) Oct 14-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Md

PARENTS

10 NAME OF FATHER Colburn

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Unknown

14 Informant Hattie Parker
(Address) 1405-Poplar Grove St

15 Filed MAR 7 - 1921 ROBERT I. CARTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5th, 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1921, to Mch 5, 1921, that I last saw her alive on Mch 24-, 1921, and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH was as follows*:

Myocardial degeneration +
Chronic Interstitial Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. Heart & urine exam.

(Signed) Irvin Eberly M. D.

3-6, 1921 (Address) 1405 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Mar. 8 1921
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified on back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51539

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51539

CERTIFICATE OF DEATH.

34

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Danie Goodyman

(a) RESIDENCE. NO. 704 W Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	White	Sing

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1 yr.	May 5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samel Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fizzie Trank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Fochlerlee
(Address) 41 Greene St

15 Filed MAR 7 - 1921 ROBERT A KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1921, to March 7, 1921, that I last saw him alive on March 7, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cellulitis of neck
(resp.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia 48 hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 7 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A O Rigby, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Helper Rosedale Cemetery	Mar 7 1921

20 UNDERTAKER M of Lenson

ADDRESS 1127 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

1 Tubercular

Spec.—8-24-14—M. & T.—2000 Bks.

Paul A. Wiechert

D51540 Paul

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51540

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 N ~~Castle~~ Chapel ST.; ~~E.~~ W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Anthony Wiechert

(Residence in Baltimore: No. 220 N Chapel St. St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH: March 5, 1921 (Month) (Day) (Year)

7-AGE: ... yrs. ... mos. 1 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: George Wiechert

11-BIRTHPLACE OF FATHER (State or Country): Balto Md.

12-MAIDEN NAME OF MOTHER: Marie Weber

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Wiechert

(Address) 220-N. Chapel St

15- Filed MAR 7-1921 ROBERT F KRAUTER, Registrar

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Mar. (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 5 1921, to Mar 6 1921, that I saw h[illegible] alive on Mar 6 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Prematur Birth (1mo)

Pneumonia

(Duration) ... yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Atelectasis

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo Luther Slades M. D.

3/7/21 (Address) 1436 E. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Pastewood Cem

DATE OF BURIAL: 3/6/21, 191...

20-UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Harford Ave

Spec. — 6-9-19 — H. P. Co. — 1000 Bks.

D51541

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51541

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1579

CITY OF BALTIMORE: (No. Md. General Hospital WARD 15)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Jones

(a) RESIDENCE. No. 2404 Powhatan ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Jones

6 DATE OF BIRTH (month, day, and year) Aug. 12, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Selsor Bros & Co Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John H Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) & & Co Md

12 MAIDEN NAME OF MOTHER Rachel A. Selsor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co Md

14 Informant Edna Jones

(Address) 2404 Powhatan Ave

15 Filed MAR 7 - 1921 ROBERT S. ... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar. 5, 1921, to Mar 5th 1921

that I last saw h alive on Mar. 5th, 1921

and that death occurred, on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Arthur L. Schumpert M. D.

. 19 (Address) 2806 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	March 8 1921
20 UNDERTAKER	ADDRESS
John Whitehead	1701 N. Fayette St

NOTE should be stated EXACTLY. PHYSICIANS should be mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Cullison

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51542

D51542

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 118 N. Bradford ST.: 6 WARD)

2-FULL NAME Milton Cullison

(a) RESIDENCE. NO. 118 N. Bradford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nobody

6 DATE OF BIRTH (month, day, and year) 13 Dec. 20

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nil. (at)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Cullison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Mary Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary Curtis
(Address) 118 N. Bradford St

15 MAR 7-1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1921

17 I HEREBY CERTIFY, That I attended deceased from
√ Mar. 1921, to —, 19—,
that I last saw him alive on √ Mar. 1921,
and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Possibly several days
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Heart failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (Home.)

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Ellwood Field Boyle M. D.

6/3 1921 (Address) 1717 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Mar 9th 1921

20 UNDERTAKER	ADDRESS
Chas G Bailey	1427 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51543

D51543

HEALTH DEPARTMENT—CITY OF BALTIMORE

91

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 W. Fayette ST.: 4 WARD)

2-FULL NAME Benjamin E. Franklin

(a) RESIDENCE. NO. 729 W. Fayette ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie E. Franklin

6 DATE OF BIRTH (month, day, and year) 3/28/1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work painter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Richmond, Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Martha Frankson
(Address) 729 W. Fayette St.

15 Filed MAR 7 - 1921 19.. WM. J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 1921, to Mar 4 1921, that I last saw h.. alive on Mar. 4th 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho- Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Isaac Glassman, M. D.

Mar 6 1921 (Address) 2687 Mekers Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Mar 8 1921
20 UNDERTAKER Margaret E. Flynn	ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51544

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51544

CERTIFICATE OF DEATH.

92-079

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.: 24 WARD)

2-FULL NAME Albert T. Landing.

(a) RESIDENCE. No. 231 E. Hamburg ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1y 1m. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Landing

6 DATE OF BIRTH (month, day, and year) July 22/1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Summer resort

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Landing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co.

12 MAIDEN NAME OF MOTHER Sudan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Benj. Landing (Address) 609 Ashland Ave

15 MAR 7 - 1921 ROBERT J. KRAUTER Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7/21

17 I HEREBY CERTIFY, That I attended deceased from 3/2/, 1921, to 3/4/, 1921, that I last saw h. alive on 3/4/, 1921, and that death occurred, on the date stated above, at 1.50 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms Symptoms

(Signed) Chas. O. Donovan, M. D.

19 (Address) 6 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Mar 7 1921
20 UNDERTAKER Margaret H. Flynn	ADDRESS 1427 Eig 4th

mation should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D51545 HEALTH DEPARTMENT—CITY OF BALTIMORE D51545

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 N Monroe St.: 70 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H Mackie

(Residence in Baltimore: No. 204 N Monroe St.; 30 yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, May 1, 1849 (Month) (Day) (Year)

7-AGE, 71 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Dry

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo H. Marks

(Address) 204 N Monroe

15- ROBERT J KRAUTER

MAR 7-1921 191... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 26 1921, to March 6 1921, that I saw h[illegible] alive on March 6 1921, and that death occurred, on the date stated above, at 12.50 p. m.

The CAUSE OF DEATH was as follows:

*Mitral Insufficiency

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Louis Eberth M. D.

3-6..., 1921. (Address) 7 W Mt Vernon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, Mar 8, 1921

20-UNDERTAKER Wm Foos ADDRESS 502 E North

CAUSE OF DEATH must be plainly written. All items important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51546 HEALTH DEPARTMENT—CITY OF BALTIMORE D51546

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No Allston Apt's.-Chas-32nd ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Nicholson Arnest.

(a) RESIDENCE. No. Allston Apartments ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 8 mos. 4 ds. How long in U. S., If of foreign birth? 69 yrs. 8 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Meletia Depkin Arnest.

6 DATE OF BIRTH (month, day, and year) July-2-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Solicitor.

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance.

(c) Name of employer E. J. Richardson & Sons.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James D. Arnest.

11 BIRTHPLACE OF FATHER (city or town) Westmore'd Co
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary Ann Stubbs

13 BIRTHPLACE OF MOTHER (city or town) West'm'ld Co.
(State or country) Virginia.

14 Informant Mrs. Meletia D. Arnest, (wife)
(Address) Allston Apts. Charles & 32nd Sts.

15 FILED MAR 7 - 1921 BOBBS & CHARTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Mch 6, 1921, that I last saw him alive on Mch 6, 1921, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease unknown

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A. Colt, M. D.

3/7, 1921 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Yeocomico Church Cemetery, Westmoreland CO., Virginia.	Mar-7- 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. This information is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D51547 HEALTH DEPARTMENT—CITY OF BALTIMORE D51547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 d Liberty Junction Hospital ST.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Shelley

(Residence in Baltimore: No. 1825 Linford Ave St.; 64 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE, W.

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (Write the word.) Widower

6-DATE OF BIRTH, June 25 (Month) (Day), 1846 (Year)

7-AGE, 74 yrs. 8 mos. 13 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stair Builder
(b) General nature of industry, business, or establishment in which employed (or employer): Building

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER Melvina Harrison

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bridy M. Shelley

(Address) 2349 Windsor Ave

15-

Filed ....., 191... ROBERT J. KRAUSE Registrar

MAR 7 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 5th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 27th 1921, to March 5th 1921, that I saw him alive on March 5th 1921, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Right Lung

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Old age & Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H D Kelly M. D.

March 6th, 1921. (Address) 1203 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Mar 8 1921

20-UNDERTAKER: Putnam & Gore — ADDRESS: 1723 W. Lafayette Ave

Cross out words not important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

251548 HEALTH DEPARTMENT—CITY OF BALTIMORE 251548

CERTIFICATE OF DEATH. 172

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital St.: 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary A Stirven

(a) RESIDENCE. No. 710 Belair Road Woodlea St.. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of John T. Stirven widowed

6 DATE OF BIRTH (month, day, and year) 1828-11-28

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	92.	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Phillip Kennard.

11 BIRTHPLACE OF FATHER (city or town) Kent Co (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Anderson

13 BIRTHPLACE OF MOTHER (city or town) Kent Co (State or country) Maryland.

14 Informant Charles W. Kennard

(Address) 215 Courtland.

MAR 7 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1921, to Mar 7, 1921, that I last saw h e alive on Mar 7, 1921, and that death occurred, on the date stated above, at 5.50 Am.

The CAUSE OF DEATH* was as follows:

Fractured Femur

6 weeks'
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) 1 week yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D.O Ridgly M. D

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington Del	3-10 1921
20 UNDERTAKER Harry W. Justice & Sons Co	ADDRESS 118 Fulton Baltimore

MATION should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall at her home,

Spec.—6-9-19—H. P. Co.—1000 Blks.

951549 HEALTH DEPARTMENT—CITY OF BALTIMORE 951549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST.; 4 WARD) REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Payne

(a) RESIDENCE. NO. 648 Redwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Payne

6 DATE OF BIRTH (month, day, and year) Aug 11, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21 -	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER John H. Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Durham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant M. Wolfe

(Address) 648 Redwood St

15 Filed MAR 7 - 1921 ROBERT N. KRAUTH Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 28th, 1921, to Mar 5th, 1921, that I last saw h[illegible] alive on Mar 4th, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of Heart

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry F. Brown, M. D.

4/5 1921 (Address) 1501 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mar 7 1921
20 UNDERTAKER Samuel F. Hemsley	ADDRESS 678 Pine

Information should be carefully supplied. Exact statements should be made. Do not use abbreviations. Write plainly so that it may be properly classified. Any physician willfully making a false statement in a CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements should be made. Do not use abbreviations. Write plainly so that it may be properly classified. Any physician willfully making a false statement in a CERTIFICATE OF DEATH is guilty of a misdemeanor. Read carefully the instructions on back of certificates. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

D 51550 HEALTH DEPARTMENT--CITY OF BALTIMORE D 51550

CERTIFICATE OF DEATH

1 PLACE OF DEATH 1820 Eutaw Place REGISTERED No. C

CITY OF BALTIMORE (No. 1820 ST. WARD 14) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2 FULL NAME Henry Rice

(Residence in Baltimore: No. Transient 1820 Eutaw Place St.: — yrs. — mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~DIVORCED~~ (Write the word): Widower

6 DATE OF BIRTH: Feb. 10, 1837 (Month) (Day) (Year)

7 AGE: 84 yrs. — mos. 24 ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9 BIRTHPLACE (State or country): Hungary

PARENTS

10 NAME OF FATHER: Louis Rice

11 BIRTHPLACE OF FATHER (State or country): Hungary.

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Hungary.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Rice (Son)

(Address) Sunbury Pa

15 Filed MAR 7 - 1921 ROBERT J. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 6th, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 5th, 1921, to March 6th 1921.

that I saw h m alive on March 6th, 1921.

and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Acute Cardiac Dilatation

(Duration) yrs. mos. 7 ds.

(Signed) Eugene Heaped M. D.

Mar 6, 1921 (Address) 803 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. 2 ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Sunbury Pa.

19 PLACE OF BURIAL OR REMOVAL: Williamsport Pa. DATE OF BURIAL: Mar. 8th 21

20 UNDERTAKER: David Sondheim ADDRESS: Mt. Royal Ave

N. B.—Every item of information should be carefully supplied. Exact statement of occupation is necessary that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is necessary that it may be properly classified. Exact statement of occupation is necessary that it may be properly classified. Exact statement of occupation is necessary

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51551 ✓ D51551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51551 4137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; 4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zetta Marston

(a) RESIDENCE. No. # 738 W. Lexington St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, (Married) Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married Unknown

6 DATE OF BIRTH (month, day, and year):

7 AGE: 23 yr

Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Emma Richards

(Address) Millbrook & Shelburne

15 MAR 7 - 1921 [illegible] Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6 1921

17 I HEREBY CERTIFY, That I attended deceased from February 21, 1921, to March 6, 1921, that I last saw h[illegible] alive on March 6, 1921, and that death occurred, on the date stated above, at 4 30 a m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia, Septic Bronchopneumonia
Phlegmasia Alba Dolens

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical symptoms

(Signed) W. L. Reyer M. D.

, 19 (Address) # University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Jackson Va.	Mar 7 1921

20 UNDERTAKER: Leo G. Cook

ADDRESS: North Harford

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 51552

Zallinsky or Liebensky

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51552

CERTIFICATE OF DEATH.

156

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Synagogue on Lurgan St. 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Zallinsky or Liebensky

(Residence in Baltimore: No. 54 n Eden St. St.: 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Married

6-DATE OF BIRTH, ..., ..., 1

(Month) (Day) (Year)

7-AGE, 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- FILED MAR 7 - 1921 ROBERT J. CLATTER Registrar 101 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 5, 1921.

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

5-5-..., 192.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Mt Carmel	3-7, 1921
20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto St

N. B.—Every item of information must be given, so that it may be properly classified. Fill out CAUSE OF DEATH in plain terms, so that it may be understood. All items important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51553 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51553

120

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Boy ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Perry.

(a) RESIDENCE. No. 550 ½ S. Charles St. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Ost

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records
(Address) City Hospital Bay View

15 Filed MAR 7 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH in plain terms. Be sure to answer every question. Do not use abbreviations. Do not write on back of certificates. INFORMATION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 1921.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1920, to March 5, 1921, that I last saw h[illegible] alive on March 5, 1921, and that death occurred, on the date stated above, at 6 30 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.
(No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) R. Heerman, M. D.

March 5, 1921 (Address) City Hospital Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	March 8, 1921
20 UNDERTAKER	ADDRESS
L. E. Brown & Son	108 W. Monty

Spec.—8-24-14—M. & T.—2000 Blks.

D-51554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37D-51554

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2317 Division ST.; 1 cent. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Paul

(Residence in Baltimore: No. 2317 Division St.; 4/12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 9 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Porter do.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltic Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Dennis

(Address) 1303 Presstman St

15- MAR 7 - 1921 ROBERT J. KRAUSER

Filed....., 191..... Burial Permit Clerk

Registrar.

CAUSE OF DEATH is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/28 1921, to 3/ 1921, that I saw h[illegible] alive on 3/5 1921, and that death occurred, on the date stated above, at 5-A m.

The CAUSE OF DEATH* was as follows:

Lathargica - encephalitis ?

Cerebral Apoplexy ?

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. Lee Roberts M. D.

3/6, 1921. (Address) 2139 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Mar 8, 1921

20-UNDERTAKER James H Dennis

ADDRESS 1303 Presstman St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 51555 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51555

9-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Smith.

(a) RESIDENCE. No. Nursery & Child's Hosp STREET WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. G. Smith

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Amy Miller

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Md.

14 Informant Miss Hutton

(Address) Nursery & Child's Hosp.

15 Filed MAR 7 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH to be plain terms, so that no other definition may be necessary. Do not use abbreviations or terms which are not commonly understood. Be sure that the answer to each question is complete. Omission of essential facts will cause unnecessary correspondence and delay. Write plainly with pen and ink. Use no lead pencil. Do not fail to answer every question. If there is none, write none, or 0, as the case may be. Do not write in margins or between lines. Do not use ditto marks. Make no erasures. Consult the reverse side of this certificate for additional instructions and suggestions. PENALTY FOR MAKING WILFULLY FALSE STATEMENTS IN THIS CERTIFICATE IS VERY SEVERE. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1921, to March 6, 1921, that I last saw h[illegible] alive on March 6, 1921, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

Measles → 9 days

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? at Hosp. & Child's

Did an operation precede death? No Date of — Hosp.

Was there an autopsy? No

What test confirmed diagnosis? Positive cultures.

(Signed) B. MacGowan, M. D.

, 19 (Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 7, 1921
20 UNDERTAKER George J. Smith	ADDRESS 1000 Fayette St.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D. 51556

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51556

74

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mt Hope Retreat

CITY OF BALTIMORE: (NO. Baltimore ST.: 38 WARD)

2-FULL NAME John Tracy

(a) RESIDENCE. NO. Mount Hope Retreat Since 1894 - ST., 28th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 0 mos. ds. How long in U. S., if of foreign birth? Not Known yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	72	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R. C. Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) not Known. Co. W. Meath - Ireland -

PARENTS

10 NAME OF FATHER Thomas Tracy

11 BIRTHPLACE OF FATHER (city or town) Co. W. Meath (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Keefe

13 BIRTHPLACE OF MOTHER (city or town) Co. W. Meath (State or country) Ireland -

14 Informant Records of Mt Hope Retreat (Address)

15 Filed , 19 Robert F. Harrison, Registrar

R 7 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1894, 19—, to March 4, 1921, that I last saw h ill alive on March 4, 1921, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Endo Cardelis, Complicated by Colilis

abt (duration) 0 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Mylancholia

abt (duration) 26 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	March 9 1921
20 UNDERTAKER	ADDRESS
Horton Father & Sons	1827 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51557

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 946 N. Duncan ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Cole

(a) RESIDENCE. NO. 946 N. Duncan St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Cole

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph Cole
(Address) 946 N. Duncan St

15 Filed 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1921, to ~~Feb~~ 3-5, 1921, that I last saw h[illegible] alive on 3-5, 1921, and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) 2 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Findings

(Signed) J. Fred Kurzrok, M. D.

3-5, 1921 (Address) 50 W. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mar 8 1921
20 UNDERTAKER	ADDRESS
Frank Brachson	1906 Eastlou[illegible]

MAR 7-1921 Burial Permit Clerk.

MAKE ENTRIES IN BLACK INK. Write DEATH in plain terms, so that it may be understood. Do not use abbreviations or ditto marks. Be particular and answer each question. Do not leave any blanks. If none, write none, or unknown, or insert 0 (cipher) where necessary. CAUSE OF

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51558 ✓ D. 51558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Lanvens. ST.: 15 WARD)

2-FULL NAME Antonio Azzarello

(a) RESIDENCE. No. 1120 Lanvens ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 4 mos. — ds. How long in U. S., if of foreign birth? 17 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug. 5- 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvadore Azzarello

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Louisa Battozilo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Santo Azzarello (Address) 1120 Lanvens

15 Filed MAR 7-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6- 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1921, to Mar 6, 1921, that I last saw h~~im~~ alive on Mar 5, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (duration) one yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regulars

(Signed) F. La Loia M. D.

1921 (Address) 313 W. Lanvens

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 3/8/1921

20 UNDERTAKER Geo. J. Ruth ADDRESS 1730 Hanford Ave.

CAUSE OF DEATH in plain terms, so that it may be understood by all certificates. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51559 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51559

CERTIFICATE OF DEATH. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 E Preston St. ST.; 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Ellsworth Leigh

(Residence in Baltimore: No. 511 E Preston St. St.; 10 yrs. 4 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, December 9 (Month) (Day), 1910 (Year)

7-AGE, 10 yrs. 3 mos. 15 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas E. Leigh

11-BIRTHPLACE OF FATHER (State or Country), D.C.

12-MAIDEN NAME OF MOTHER Bessie Appleby

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie E. Leigh

(Address) 511 E. Preston St.

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk.

MAR 7 1921 Registrar.

CAUSE OF DEATH to plainly written or typewritten. Information important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1920, to March 6 1921, that I saw h- alive on March 6 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ? ds.

(Signed) Thos. J. Kelly M. D.

March 7, 1921. (Address) 701 E. 35th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL, March 10, 1921

20-UNDERTAKER H B Hepfer

ADDRESS 2236 Fremont Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51560 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51560

CERTIFICATE OF DEATH. X 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2920 Laurens ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Carrie Helen Twomey Hatch

(a) RESIDENCE. NO. 48 Main St Somersworth N Hamp ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Hatch

6 DATE OF BIRTH (month, day, and year) Feb 24-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somersworth new hampshire

PARENTS

10 NAME OF FATHER Thomas C. Twombly

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Carrie Augusta Twombly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portsmouth N. H.

14 Informant A Edwin Hatch (Address) 2920 Laurens St City

15 Filed MAR 7-1921, 19.....

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1921, to March 6, 1921, that I last saw her alive on March 6, 1921, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights disease (duration) about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) about 1 yr. mos. ds.

18 Where was disease contracted if not at place of death? Her former home in N.H.

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. B. Stansbury, M. D.

19 (Address) 714 Park Ave, Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Somersworth N. H

DATE OF BURIAL March 7 1921

20 UNDERTAKER W. A. Tuckner & Son

ADDRESS Walker

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51561 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51561

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH St. Agnes Hospital REGISTERED NO.

CITY OF BALTIMORE: (NO. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Wilkens

(a) RESIDENCE. NO. 14 E. Virginia ave. WARD. Egg Harbor N.J.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not employed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Elizabeth M. Newman
(Address) 14 East Virginia Ave

15 Filed Robert P. Harrison, Registrar
MAR 7-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-16-, 1921, to 3-6-, 1921, that I last saw her alive on 3-6-, 1921, and that death occurred, on the date stated above, at 10:50 P.m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis -
myocarditis with
acute dilatation.
(?) - (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Passive Congestion Lungs with pulmonary edema. (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? No Date of

Was there an autopsy? No-

What test confirmed diagnosis? Clinical findings.

(Signed) Paul E. Brown, M. D.

3-6-1921 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
EGG HARBOR CITY. N.J.	MAR 9. 1921
20 UNDERTAKER Robert Brokerson	Funeral Home Hallinan

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51562 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51562

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2643 Eastern Ave ST.; 1 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Julia A. Conry,

(Residence in Baltimore: No. 2643 Eastern Ave. St.; 58 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow.

6-DATE OF BIRTH, Sept. 10, 1851
(Month) (Day) (Year)

7-AGE, 69 yrs. 5 mos. 24 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country) Ireland.

PARENTS.

10-NAME OF FATHER, Thomas McDonogh,

11-BIRTHPLACE OF FATHER (State or Country) Ireland,

12-MAIDEN NAME OF MOTHER Hannah Green,

13-BIRTHPLACE OF MOTHER (State or Country) Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie Connally,

(Address) 2643 Eastern Ave

15-

Filed ....., 191.... Robert P. Harrisen, Registrar.

Burial Permit Clerk

MAR 7 - 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 6 1921, to March 6th 1921, that I saw h[illegible] alive on March 5th 1921, and that death occurred, on the date stated above, at 3:20 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Chastworthy M. D.

3/6, 1921 (Address) 888 N. Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Patrick's Cem. DATE OF BURIAL, 3-8, 1921

20-UNDERTAKER L. A. Moran ADDRESS 3000 E. Baltimore

CAUSE OF DEATH must be stated in plain English. Do not use abbreviations. Be particular and answer each question. Every certificate must be signed. Your certificate is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51563 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51563

CERTIFICATE OF DEATH.

80

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 E Biddle ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Murphy

(Residence in Baltimore: No. 720 E Biddle St. 50 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, unknown (Month), 1 (Day) (Year)

7-AGE, 62 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Terence Murphy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hugh Dalon

(Address) 720 E Chase St

15- Filed ..... 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

AR 7-1921

CAUSE OF DEATH must be filled in. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 5 1921, to March 21 1921, that I saw her alive on March 21 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

angina Pectoris

(Duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) 1 yrs. ... mos. ... ds.

(Signed) Jas. H. Taylor M. D.

Mar 7, 1921. (Address) 720 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, 3/7, 191...

20-UNDERTAKER Jno J Dalton & Sons — ADDRESS 1318 Light

20.51564 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51564

Husband John.

CERTIFICATE OF DEATH.

1775-001

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No.) 1 Edward E. Calvert St. (ST.) (WARD) REGISTERED No. C

2-FULL NAME Rosalia Krebs

(Residence in Baltimore: No. 15 S. Howard St.) (yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July 23 1868 (Month) (Day) (Year)

7-AGE, 52 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home Keeping
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Matthias Goldmer

11-BIRTHPLACE OF FATHER (State or Country) Austria

12-MAIDEN NAME OF MOTHER Rosa Shuss

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Krebs

(Address) 1512 Calvert

15- Filed MAR 7 1921, 191

Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 5, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains deserибed above, held an August (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident
Multiple Fractures

(Duration) yrs. mos. 1 hr. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) Geo. Lum Blake M. D.
(Coroner.)

3/7/21, 191... (Address) 1430 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs...mos...ds. In the State ...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, March 8. 1921

20-UNDERTAKER Wendell Diffenderffer & Son — ADDRESS 37 S. Howard

EVERY item must be filled in. CAUSE OF DEATH in plain terms, so that it may be property classified. Every item important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51565 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51565

CERTIFICATE OF DEATH. X 28

1-PLACE OF DEATH U.S.P.H.S Hospital #56 REGISTERED NO.

CITY OF BALTIMORE: (No. Ft. McHenry, Baltimore, Md ST.: 24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard C. Bangley

(a) RESIDENCE. No. U.S.P.H.S Hosp.-#56, Balto. Md.- ST.:- WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Inspector.

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 086

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) VA.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edna T. Rowbuck (Address) U.S. PHS. Hosp. #56 Ft McHenry Md. Registrar.

15 Filed MAR 7-1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from 1/16/21, 19..., to 3/6/21, 19..., that I last saw him alive on 3/6/21, 19..., and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? - Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. & Laboratory Test

(Signed) Thomas B. Payne, M. D. Senior Surgeon (R)

19 (Address) USPHS Hosp. #56, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Suffolk Va	Mar 7 1921
20 UNDERTAKER S. Grimson & Bro	ADDRESS 1127 E Balto St

CAUTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.515.66 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51566

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3611 Govane Ave (St.) 19 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza M. Michel

(a) RESIDENCE. NO. 3611 Govane Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob M. Michel

6 DATE OF BIRTH (month, day, and year) Jan 23 - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work AX Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Frederick Klee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Gentzler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary M. Michel

(Address) 3611 Govane Ave

15 [illegible] Robert F. [illegible]

B7-1921 , 19 Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1921, to Mar. 6, 1921, that I last saw h[illegible] alive on Mar. 5, 1921, and that death occurred, on the date stated above, at 1150a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Right)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Hoen, M. D.

3-6, 1921 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	19
20 UNDERTAKER William Cook	ADDRESS 5016 North

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51567 HEALTH DEPARTMENT—CITY OF BALTIMORE D.5.15.67

CERTIFICATE OF DEATH. 144

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Barbara Steutz

(a) RESIDENCE. No. 23 East Ave Belair Rd ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER Charles Stratz

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary Barr

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant New City Hosp. Records (Address)

15 Filed Robert P. Harrison, Registrar

3-7-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-5 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-24, 1921, to 3-5, 1921, that I last saw her alive on 3-5, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute suppurative Parotitis

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary) Septicemia + Acute heart failure (duration) 30 Min. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 2-27-21

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Holden M. D.

3-6, 1921 (Address) New City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	March 7-1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Multiple abscess of leg which caused parotitis. Not used in redose of mumps. Operation for drainage of abscess.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-51568 HEALTH DEPARTMENT—CITY OF BALTIMORE D-51568

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sadie Robeson

(a) RESIDENCE. NO. 302 E. 31st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Charles E. Robeson

6 DATE OF BIRTH (month, day, and year) Jan. 16-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~80~~	57	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Charles H. Robinson
(Address) 1538 Park Ave.

15 Filed Mar 7 - 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1921

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1921, to March 6, 1921, that I last saw h e alive on March 6, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory test

(Signed) C. O. Bulgley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 9 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. Math Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51569 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51569

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 N Bethel ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antoni Gorera

(a) RESIDENCE. No. 1518 N Bethel ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds How long in U. S., if of foreign birth? life yrs. mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna E Gorera

6 DATE OF BIRTH (month, day, and year): Dec 31 1886

7 AGE: Years 34 | Months 3 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Antoni Gorera

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Anna E Gorera (Address): 1518 N Bethel St

Filed 3-7-1921 Robert P. Harrison, Registrar

Mc Donald 1540 N Broadway. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1921, to Mar. 6, 1921, that I last saw him alive on Mar 6, 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): (duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A W Macdonald, M. D.

3/7/1921 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral | DATE OF BURIAL: Mar 1921

20 UNDERTAKER: W. Cook | ADDRESS: 5026 Belair Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

5/569

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

5/569

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1518 N Bethel ST.; WARD) (If death a hospital tion, give instead of number.)

2-FULL NAME Antoni Gorna

(a) RESIDENCE. NO. 1518 N Bethel ST., WARD.
(Usual place of abode) (If nonresident give city or town

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna E Gorna

6 DATE OF BIRTH (month, day, and year) Dec 31/1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	34	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Antoni Gorna

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Anna E Gorna
(Address) 1518 N Bethel St

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended d
Mar 3, 1921, to Mar 5
that I last saw him alive on March 5
and that death occurred, on the date stated above, at 8.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mo

CONTRIBUTORY (Secondary) Lobar Pneum

(duration) yrs. m

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A L MacDonald M.D.

Mar 6 1921 (Address) 1540 N Broa

*State the Disease Causing Death, or in deaths from Vio state (1) Means and Nature of Injury, and (2) whether Suicidal, or Homicidal. (See reverse side for additional spac

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE

New Cathedral Mau

20 UNDERTAKER — ADDRE

Wm Leal 1028 N Bal

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51570

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51570

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Harford Rd & Berwick Ave. WARD)

2-FULL NAME Mary Shelby

(a) RESIDENCE. NO. 1 Harford Ave & Berwick ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Casper Shelby

6 DATE OF BIRTH (month, day, and year) Oct. 17 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John Buechey

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna E Eyler

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Margaret Griffin
(Address) Harford Rd & Berwick Ave

15 Filed MAR 7 1921 Registrar

D 4 Hornstein 733 Argyle St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1921, to March 7, 1921, that I last saw her alive on March 7, 1921, and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 812 Harford Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

3/7, 1921 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	March 9 1921

20 UNDERTAKER Wm Cahoon & Sons

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51571 HEALTH DEPARTMENT—CITY OF BALTIMORE D51571

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. | WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Yeroshek

(a) RESIDENCE. No. 503 S. Chester st. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Yaroshek (Address) 503 S. Chester

15 FILED MAR 8-1921 REGISTRAR Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1921, to March 6, 1921, that I last saw h.. alive on March 6, 1921, and that death occurred, on the date stated above, at 1.55 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis T.B. in sputum, X-ray

(Signed) Jos. H. Falkovich, M. D.

3-7-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL May 8 1921

20 UNDERTAKER M. Frankowski ADDRESS 168 Eastern

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D51572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51572

CERTIFICATE OF DEATH.

124

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 W. Lanvale ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Pratt

(Residence in Baltimore: No. 802 W. Lanvale St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): widowed

6-DATE OF BIRTH, Don't know birth day (Month) (Day), 1840 (Year)

7-AGE, 81 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Walker

(Address) 802 N. Lanvale St.

15- Filed MAR 8 - 1921, 191.. ROBERT S. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1920, to March 6 1921, that I saw her alive on March 1. 1921, and that death occurred, on the date stated above, at 1.10 p. m.

The CAUSE OF DEATH* was as follows:

Senile Arterio Sclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) W. C. Sandrock M. D.

Mar 7., 1921. (Address) 1242 N. Broadway.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Mch. 8., 1921.

20-UNDERTAKER Mrs J. S. Locks ADDRESS 1302 Jefferson st.

important. See instructions on back of certificate.

D51573 HEALTH DEPARTMENT—CITY OF BALTIMORE D51573

CERTIFICATE OF DEATH. 175-003

1-PLACE OF DEATH, CITY OF BALTIMORE (No. W. Royd Station B & O R.R. St.; WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack Lewbart

(Residence in Baltimore: No. St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	M

6-DATE OF BIRTH, Unknown, 1887
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
34 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) of R. L. Goodwin B & O

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Baltimore

15- Filed MAR 8-1921 191... ROBERT E KRAUTER Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omissions will delay certificate. Abbreviations are not important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Contusion 3 hours
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Shock
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. Claude Bloede M. D.
(Coroner)
3/7/21, 191... (Address) 1436 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Camden N. J.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mehren Mt Carmel	3-8, 1921
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51574 HEALTH DEPARTMENT—CITY OF BALTIMORE D51574

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 Chauncey ave St.: 12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Silver

(a) RESIDENCE. No. 826 Chauncey ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Silver

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant I. Lewis (Address) 1411 E Balto

15 Filed MAR 8 1921 ROBERT J. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1914, to March 7, 1921, that I last saw him alive on March 7, 1921, and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cancer Stomach & Liver, Valvular Heart Disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Michael A. Abrams, M. D.

, 19 (Address) 2360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodef Sholom	3-8 1921
20 UNDERTAKER	ADDRESS
I. Lewis	1411 E. Balto

TION is very important. See instructions on back of certificate.

D51575 HEALTH DEPARTMENT—CITY OF BALTIMORE 9 D51575

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1010 Plum Alley. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Collis R. Sewell. (C).

(Residence in Baltimore: No. 1010 Plum Alley. St.: ----- yrs., 9 mos., -- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, ... June 2nd., 1920. ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
---yrs. 9 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Clarence Sewell. (C).

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Nettie McLaughlin. (C).

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Sewell. (C). (mother).

(Address) 1010 Plum Alley

15- Filed MAR 8 - 1921 191... ROBERT J. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March 6th. 1921. ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ...inquiry... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ...[illegible]... (Inquest, autopsy or inquiry.) find that said deceased came to his... on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
.....Broncho-pneumonia.
.....Unknown.
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto H. Eisenhardt M. D.
(Coroner.)

Mar. 7th, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Mch 8, 1921

20-UNDERTAKER John H. Toadvine — ADDRESS 1427 Pulaski St

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms,

Spec.—8-24-14—M. & T.—2000 Bks.

D51576

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51576

CERTIFICATE OF DEATH.

8-091

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Wilhelm St., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irving Morton Stitt

(Residence in Baltimore: No. 2000 Wilhelm St St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, March 28, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 11 mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, Martin Stitt

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Minnie Miller

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin G Stitt

(Address) 2000 Wilhelm St

15- MAR 8-1921 Filed....., 191.... ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 2 1921, to March 7 1921, that I saw h alive on March 7 1921, and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Atelectasis Cyanosis
Prematurity

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Atelectasis

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Robert H Hunt M. D.

March 7, 1921 (Address) 2000 Wilhelm St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral and Aloca | DATE OF BURIAL, Mar 10 1921

20-UNDERTAKER Krell & Son | ADDRESS 172 W Pratt

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D51577 HEALTH DEPARTMENT—CITY OF BALTIMORE D51577

CERTIFICATE OF DEATH.

REGISTERED NO. C 676

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Ethel Mendel

(Residence in Baltimore: No. 1935 Orleans St St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1869 (Year)

7-AGE, 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Baltimore

15-MAR 8-1921 ROBERT I. KRAUTER

Filed ....., 191... Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 7th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 20 1921, to March 7th 1921, that I saw h[illegible] alive on March 7th 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia Hemorrhagic
(Stupor, Hemiplegia)

(Duration) yrs. 13 mos. ds.

CONTRIBUTORY (Secondary) Otitis Media (purulent)

(Duration) yrs. mos. 21 ds.

(Signed) [illegible] M. D.

3/12/21 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State 8 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1938 Orleans St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 3-8, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Baltimore

important. See instructions on back of certificate.

D51578 HEALTH DEPARTMENT—CITY OF BALTIMORE D51578

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 410 S. Wolfe St. 7 WARD) REGISTERED No. C 792

2-FULL NAME Albert P. Jackson

(Residence in Baltimore: No. 410 S. Wolfe st

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 6th yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. August (Month) 6 (Day), 1844 (Year)

7-AGE. 76 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or mts.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Night Watchman
(b) General nature of industry, business, or establishment in which employed (or employer). Blatt & Co

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Martha W. Jenkins

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jenkins

(Address) 410 S. Wolfe St.

15-MAR 8-1921 Filed, 191... [illegible] Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart disease (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Mar 8 '21, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem. DATE OF BURIAL, March 9, 1921

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Pict St.

D51579 HEALTH DEPARTMENT—CITY OF BALTIMORE D51579

CERTIFICATE OF DEATH. REGISTERED No. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 119 n Belnard St. 6 WARD) (If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Schmidt

(Residence in Baltimore: No. 119 n Belnard. St.; 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	wht	Married

6-DATE OF BIRTH, January 3, 1918. (Month) (Day) (Year)

7-AGE, 3 yrs. 2 mos. 0 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Herman Schmidt

11-BIRTHPLACE OF FATHER (State or Country) Baltimore, Md.

12-MAIDEN NAME OF MOTHER Mary Woolworth

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Schmidt

(Address) 119 N. Belnard Ave

15- Filed MAR 8 - 1921 ROBERT J. KRAUTER Registrar.

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 6, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. fell over backs of hot water

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. F. Smiley M. D.
(Coroner)

3-7, 1921. (Address) 69 E. Fleet

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Mar 9, 1921
20-UNDERTAKER	ADDRESS
A Sander & Sons	1710 Fleet St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51580

HEALTH DEPARTMENT--CITY OF BALTIMORE

D51580

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 S. Highland Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Berends

(a) RESIDENCE. NO. 4 S. Highland Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernhard Berends

6 DATE OF BIRTH (month, day, and year) June 10, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home Dd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Jennie Jacobs (Address) 4 S. Highland Ave

15 Filed MAR 8 - 1921 ROBERT F. KRAUTER Registrar

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/25/21, 19..., to 3/5/21, 19..., that I last saw her alive on 3/5/21, 19..., and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs + Symptoms

(Signed) H. H. Hohmann, M. D.

3/6, 1921 (Address) 2919 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	March 9 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be classified. See rules and list of certificates.
TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51581 HEALTH DEPARTMENT—CITY OF BALTIMORE D51581

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 25 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Louis Kesting

(a) RESIDENCE. No. Mt. Wimans Mld ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 6 - 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ old

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas A. Kesting

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Chas. A Kesting (Address) Mt Wimans Mld.

15 Filed MAR 8 - 1921 ROBERT I. KRAUTH Registrar

Bureau Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1921, to Mar 7, 1921, that I last saw h[illegible] alive on Mar 7, 1921, and that death occurred, on the date stated above, at 11[illegible] A.m.

The CAUSE OF DEATH* was as follows:

Acute Tetanus

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Phrenic spasm 10 min

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Jr. V. Hooper, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 10 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Eastern Ave

CAUSE OF DEATH in plain [illegible] TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Splitter in finger

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51582

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51582

CERTIFICATE OF DEATH.

REGISTERED NO. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 N. Spring ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Faye Jones

(a) RESIDENCE. NO. 702 N. Spring ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/15/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Barnard Laurence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mable Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Barnard Laurence
(Address) 702 N Spring St

15 Filed MAR 8 - 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1921

17 "I HEREBY CERTIFY," That I attended deceased from March 3, 1921, to March 5, 1921, that I last saw h[illegible] alive on March 5, 1921, and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH was as follows: Capillary bronchitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dr. Robinson, M. D.

3/7/21 (Address) 1520 E Monument St

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albany Cemetery

DATE OF BURIAL Mar 8 1921

20 UNDERTAKER K & Gross

ADDRESS 1400 Mc Elderry

CAUSE OF DEATH to be filled in by physician. See instructions on back of certificates. TION is very important.

Dec.—6-9-19—H. P. Co.—1000 Bks.

D51583 HEALTH DEPARTMENT—CITY OF BALTIMORE D51583

CERTIFICATE OF DEATH.

18 37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1102 W Lexington ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Tucker

(a) RESIDENCE. No. 1102 W Lexington ST.. WARD. Surry Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced (or) WIFE of Alex Tucker

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Surrey Co Va

PARENTS

10 NAME OF FATHER Hallis Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Surrey Co Va.

12 MAIDEN NAME OF MOTHER Mussan ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lelia Ballard

(Address) 1102 W Lexington St

15 Filed MAR 8 - 1921 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1/21. 19 . to Mar 6. 1921.

that I last saw h. alive on Mar 6 . 1921.

and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E William Frey, M. D.

3/7. 1921 (Address) 1928 Pa. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mar 8 1921
20 UNDERTAKER	ADDRESS
Samuel Hendley	Md

CAUSE OF DEATH must be filled in plainly and completely. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51584 HEALTH DEPARTMENT—CITY OF BALTIMORE D51384

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 20 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelson Dell

(a) RESIDENCE. No. 2885 W. Baltimore, St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John Dell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records,

(Address) New City Hospital

15 Filed MAR 8 - 1921 19 ROBERT I. [illegible] Registrar

Burial Permit Given

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1921

17

I HEREBY CERTIFY, That I attended deceased from January 27, 1921 to March 6, 1921 that I last saw him alive on March 6, 1921 and that death occurred, on the date stated above, at 11:55 P.m.

The CAUSE OF DEATH* was as follows:

Fracture of Hip. (duration) yrs. mos. 38 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) E. A. Holden, M. D.

3/7/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	March. 9 1921
20 UNDERTAKER Joseph B. Cook.	ADDRESS 1003 N. Balto St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fell out of Bed while asleep.

Spec.—6-9-19—H. P. Co.—1000 Bks.

951585 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 951585

CERTIFICATE OF DEATH.

91

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 544 Orchard St. ST.: 17 WARD)

2-FULL NAME Selton M. Mitchell

(a) RESIDENCE. No. 544 Orchard St. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Mar. 30-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	2	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Albert Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Camden S.C.

12 MAIDEN NAME OF MOTHER Annie Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Franklin Va.

14 Informant (Address) Albert Mitchell 544 Orchard

15 Filed MAR 8th 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1921, to March 7, 1921, that I last saw him alive on March 6, 1921, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Croup & Bronchitis 2 yrs 7 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) D. G. W. Kennard, M. D.

3-7, 1924 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Mar 8 1921

20 UNDERTAKER Samuel Hensley & Biddle ADDRESS 87

CAUSE OF DEATH in plain ... TION is very important. See instructions on back of certificates.

D51586 HEALTH DEPARTMENT—CITY OF BALTIMORE D51586

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2623 N. Henry ST.: 20 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas E. Shaw

(Residence in Baltimore: No. 2523 N. Henry St.: (yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, Sept (Month) 25 (Day), 1844 (Year)

7-AGE, 76 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): United R.R.'s

9-BIRTHPLACE, (State or Country), Mass.

PARENTS.

10-NAME OF FATHER, Samuel Shaw

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Elizabeth Walker

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret E. Shaw

(Address) 2523 N. Henry

15-

Filed MAR 8-1921 ROBERT J. KRAUTER Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 6 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH*, was as follows:

Ends Cardiac

(Duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis & heart trouble

(Duration) yrs. mos. ds.

(Signed) James M Fenlon M. D. (Coroner.)

Mar 6 1921. (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Co	March 7, 1921
20-UNDERTAKER, Joseph B. Cook	ADDRESS 1003 N. Bulls St.

N.B.—Every item of information should be given as fully as possible, so that it may be properly classified. Place of death, CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D51587 HEALTH DEPARTMENT—CITY OF BALTIMORE D51587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1417 N Fulton Ave 15 WARD) ST.

REGISTERED No. C 89

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia C. Rebel.

(Residence in Baltimore: No. 1417 N Fulton Ave St.; 7 yrs., 8 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, June 10, 1918
(Month) (Day) (Year)

7-AGE, 2 yrs. 8 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Edward Rebel

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Lillian McElroy

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Rebel
(Address) 1417 N. Fulton Ave

15-
ROBERT L KRAUSE
Filed MAR 8 - 1920 191.... Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Mar 6 -, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lob. Bronchitis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Robert Blake M. D.
(Coroner.)

3/9/20 191... (Address) 1417 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	March 8, 1920
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly examined. Each answer important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51588

CERTIFICATE OF DEATH.

92-010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3218 Payson St.; Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Biedenkapp

(Residence in Baltimore: No. 3218 Payson St.; 38 yrs., ... mos. ..... ds.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) 16 (Day), 1858. (Year)

7-AGE, 62 yrs. 6 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Biedenkapp

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Derbing

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Biedenkapp

(Address) 3218 E. Payson St.

15-

Filed ....., 191.....

ROBERT J. KRAUTER
Registrar.

MAR 8 - 1921 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1 1921, to March 4 1921

that I saw him alive on March 4 1921

and that death occurred, on the date stated above, at 3 P m

The CAUSE OF DEATH* was as follows:

Influenza, Labor

Pneumonia

(Duration) ..... yrs. ..... mos. 3 d

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 1 d

(Signed) Robert F. C. Kelch M.

March 7, 1921 (Address) 251 Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL Mar 8, 1921

20-UNDERTAKER George Lehnert & Bro

ADDRESS 3101 Pitts

D51589 HEALTH DEPARTMENT—CITY OF BALTIMORE D51589

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1025 N Carey St. 16 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Miles

(Residence in Baltimore: No. 1025 N Carey St. 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March ....., 1881
(Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dock

9-BIRTHPLACE, (State or Country), N. C

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Miles

(Address) 1025 N. Carey St

15- MAR 8 — 1926 191.. [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH March 6, 1926
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

Contributory (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

[illegible] 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, March 9, 1926

20-UNDERTAKER Chas. H. Chase & Son — ADDRESS 1400 Madison

N. B. Every item of CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51590

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51590

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 24 WARD)

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Taylor

(a) RESIDENCE. No. Unknown 1406 Jackson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records. (Address): New City Hospital.

15 Filed MAR 8 1921, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1915, to March 6, 1921

that I last saw him alive on March 6, 1921

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Art. sclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) C B Sherman, M. D.

3/7/. 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	3/9-21
20 UNDERTAKER	ADDRESS
J. F. McCully	130 E. Fort.

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51591

D51591 64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Balto., Md.

CITY OF BALTIMORE: (No. 320 N. Gilmor St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Hurley

(a) RESIDENCE. No. 320 N. Gilmor St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower.

6 DATE OF BIRTH (month, day, and year) Feb 10th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, pensioned. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. & Ohio Railroad.

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Hurley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER does not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Lehner
(Address) 220 S Gilmor st

15 Filed MAR 8 - 1921 19 ERNEST J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, 19..., to March 6, 1921, 19...

that I last saw him alive on March 6, 1921. 19...

and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Hemiplegia, and paralysis.

MW

three days. (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Paralysis.
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of

Was there an autopsy? -

What test confirmed diagnosis? -

(Signed) John Dwyer, M. D.

, 19 (Address) 904 N Charles st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Mar 9th 19...
20 UNDERTAKER John Fields	ADDRESS 1200 N. Eutaw st

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This information is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Crumblett

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51592 HEALTH DEPARTMENT—CITY OF BALTIMORE D51592

CERTIFICATE OF DEATH.

REGISTERED NO. 132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Blanche Crumblett

(a) RESIDENCE. NO. 920 Ryan ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry E. Crumblett

6 DATE OF BIRTH (month, day, and year) aug 10, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Welch

11 BIRTHPLACE OF FATHER (city or town) (State or country) virginia

12 MAIDEN NAME OF MOTHER Mary Hackless

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Harry Crumblett (Address) 920 Ryan Ave

15 FILED MAR 8 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH. This information is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1921, to Mar 8, 1921, that I last saw h e alive on Mar 8, 1921, and that death occurred, on the date stated above, at 1 9. m.

The CAUSE OF DEATH* was as follows:

Salpingitis & ovarian cyst

ovar

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Septicemia (streptococci

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Mar 5, 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lymon S. Abbott, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Mch 10 1921
20 UNDERTAKER Wm Cook	ADDRESS N. Gilmor

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Gonococcus infection

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51593 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51593

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 4448 Norwood Ave. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Francis Schuhoff

(a) RESIDENCE. No. 4448 Norwood Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 27 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wilbur F. Schuhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bal'e Co.

12 MAIDEN NAME OF MOTHER Marie E. Bolk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Wilbur F. Schuhoff (Address) 4448 Norwood Ave

15 Filed MAR 8 - 1921 19 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1921, to Mar 7, 1921, that I last saw h[illegible] alive on March 7, 1921, and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus (congenital atelectasis) (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Prematurity (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physician

(Signed) A. M. Feldman, M. D.

, 19 (Address) 2631 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem & Mark	1921
20 UNDERTAKER	ADDRESS
J W Beck	5328 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51594

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 24 WARD) 35

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Locke

(a) RESIDENCE. No. US. Public Health Hosp. #56 ST.. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs William A Locke

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27 yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: weaver

(b) General nature of industry, business, or establishment in which employed (or employer): unknown

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant Edgar T. Rowbotham Registrar
(Address) US. PHS Hosp. #56 Ft. McHenry Md.

15 FILED MAR 8 - 1921 19 ROBERT E KRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that a non-medical person may understand it. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12 1921 to March 6, 1921 that I last saw him alive on March 6, 1921 and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam & Laboratory Report

(Signed) Thomas R. Payne M. D.
Senior Surgeon (U.S.P.H.S.)

, 19 (Address) US. P.H.S. Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winchester Va	Mar 8 19 21

20 UNDERTAKER J. Pierson & Bro

ADDRESS 1127 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D81595 HEALTH DEPARTMENT—CITY OF BALTIMORE D81595

CERTIFICATE OF DEATH. X 1

1-PLACE OF DEATH US. Public Health Service Hosp. #56

CITY OF BALTIMORE: (No. Fort Mc Henry Baltimore Md. 24 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caprice Jackson

(a) RESIDENCE. NO..... ST. US. Public Health Service Hosp. #56, WARD. 51

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) ----

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edna T. Rosenbrock Registrar

(Address) US. PHS Hosp. #56 Ft. McHenry Md.

15 Filed MAR 8-1921 ODELL L. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec. 10 1920 19 , to March 4, 1921 19 .

that I last saw him alive on March 4, 1921 , 19 .

and that death occurred, on the date stated above, at 2'45 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

10 weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ---

Was there an autopsy? Yes.

What test confirmed diagnosis? Exam.

(Signed) Thomas R. Rayner Surgeon U.S.N. M.D.

, 19 (Address) US. PHS Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL March 8 192

20 UNDERTAKER S. Spencer & Son

ADDRESS 1127 E Baltimore

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Majcher. D 51596

D 51596

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

O.K. 170 The Owens Co. 20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Monument ST.: Ward)

2-FULL NAME Peter Majcher

(a) RESIDENCE. No. 2002 Monument ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Regina Majcher.

6 DATE OF BIRTH (month, day, and year) Dec 6 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Labour. Ofc

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Wojciech Majcher.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Ukos.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Regina Majcher. (Address) 2002 Monument St.

15 Filed MAR 8 - 1921 ERNEST J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. , 19 20 , to Mar 7 - , 19 21 ,

that I last saw h.. alive on Feb 6 - , 19 21 ,

and that death occurred, on the date stated above, at 2302 m.

The CAUSE OF DEATH* was as follows:

Aortic + Mitral Regurg.

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) A. T. Ries, M. D.

Mar 7, 1921 (Address) 24 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem	Mar 9" 1921
20 UNDERTAKER M. F. Sadowski.	ADDRESS 905 S. Ann

CAUSE OF DEATH: In plain terms, so that a non-medical person may understand it, and state the MODE OF DYING, as to whether by disease, accident, suicide or homicide. Do not use abbreviations or technical terms. Do not state the mode of dying, such as heart failure, asthenia, etc., but the disease or injury which caused death. Local conditions should not be stated unless they were the cause of death. If deaths occurred in hospitals or institutions, the primary cause which led to admission should be given. If death was due to external causes, state the accident, suicide or homicide, and how it occurred. If from a wound, burn or injury, state the nature of the injury, and the part of the body affected. If a woman, whether pregnant or recently delivered. If a child, how long after birth. If from accident, state whether it occurred while at work, and the nature of the work. This information is very important. See instructions on back of certificates.

D51597 HEALTH DEPARTMENT—CITY OF BALTIMORE D51597

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1120 W. Fullerton ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dolphus Diggs

(Residence in Baltimore: No. 1120 W. Fullerton St. 5 yrs., 5 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	Single

6-DATE OF BIRTH, Jan 3, 1894
(Month) (Day) (Year)

7-AGE, 27 yrs. 2 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Thomas Diggs

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Susie Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Parker

(Address) 1120 W. Fullerton St.

15-MAR 8-1921 ROBERT J. KRAUTER
Filed....., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. Edward Blake M. D.
(Coroner.)

3/3/21, 191.. (Address) 1403 Bonney

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Mar 8 1921
20-UNDERTAKER	ADDRESS
Edw. Ringgold	1463 N. Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

D51598 HEALTH DEPARTMENT—CITY OF BALTIMORE D51598

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH, CITY OF BALTIMORE (No.) 1217 Winchester St. (Ward) 16 103

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Harvey.

(Residence in Baltimore: No. 1217 Winchester St., St. 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH: June (Month) 24 (Day), 1880 (Year)

7-AGE: 40 yrs. 8 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): N. Carolina

PARENTS.

10-NAME OF FATHER: Junius Bryant

11-BIRTHPLACE OF FATHER (State or Country): N. Carolina

12-MAIDEN NAME OF MOTHER: Annie Brown

13-BIRTHPLACE OF MOTHER (State or Country): N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irvin Harvey

(Address) 1217 Winchester St.

15- ROBERT J. KRAUSE

FILED MAR 8 - 1921 ..... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

AC Gastritis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. (....ds.

(Signed) G. C. Shadis M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet

DATE OF BURIAL, Mar 10, 1921.

20-UNDERTAKER: Edw. Quiggold

ADDRESS 1463 N. Carey

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51549 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51549

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1220 Hollins St. (Ward) 18

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Regina Smith

(a) RESIDENCE. No. 1220 W. Hollins St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb 16 1920

7 AGE: Years — Months 1. Days 21. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — none

(b) General natore of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: H. A. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Helen Maddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Walter A Smith

(Address) 1220 Hollins

15 Filed MAR 8 - 1921 19 ROBERT P. KRAUTH Registrar

Burial Permit Oleeb

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 22 1921, to March 7, 1921, that I last saw her alive on Feby 22, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Keratо Titis

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clam

(Signed) J. H. D. Cliff Jr, M. D.

(Address) 27 N. Carey Ave Disp

*State the Disease Causing Death, or in deaths from Violent Caoses, state (1) Means and Nature of Injory, and (2) whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Mar 8th 1921

20 UNDERTAKER: H B Kuhlmann — ADDRESS: 223 E Fayette Ave

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D51600 HEALTH DEPARTMENT—CITY OF BALTIMORE D51600

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3029 Westwood ave ST.; 15 WARD) REGISTERED NO. C 159

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Santo Dominic Serio

(Residence in Baltimore: No. 3029 Westwood ave St.; 6 yrs., 3 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Single

6-DATE OF BIRTH, Nov. 22nd, 1914. (Month) (Day) (Year)

7-AGE, 6 yrs. 3 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer)..... Boy

9-BIRTHPLACE, (State or Country), City.

PARENTS.

10-NAME OF FATHER, Frank Serio.

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Rosaria Forty

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosaria Forty

(Address) 3029 Westwood ave

15- Filed MAR 8-1921, 191.... ROBERT E TRAUTER Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 7th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-27-1921, to 3-7-1921, that I saw h[illegible]alive on 3-7-1921, and that death occurred, on the date stated above, at 9.35 m.

The CAUSE OF DEATH* was as follows:

Diphtheria -

(Duration) .....yrs. .....mos. 13 ds.

CONTRIBUTORY (Secondary) Myocarditis -

(Duration) .....yrs. .....mos. 6 ds.

(Signed) S. Bonanno M. D.

3-8-, 1921 (Address) 1604 Linden ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Cathedral Cemetery	Mar. 8, 1921.
20-UNDERTAKER	**ADDRESS**
H M Rowson	2238 N North ave

Important. See Instructions on back of Certificate.

S.—6-9-19—H. P. Co.—1000 Bks.

D51601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51601

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 516 St. Marys (St.) 17 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lattie Hawkins

(a) RESIDENCE. No. 516 St. Marys ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eugene Hawkins

6 DATE OF BIRTH (month, day, and year) Abt. 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bertha Thomas (Friend)
(Address) 510 St. Mary St.

15 MAR 8 - 1921

ROBT. J. KRAUTH
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6/1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1921, to Mar 6, 1921, that I last saw h[illegible] alive on Mar 5, 1921, and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Gen. exhaustion

(duration) yrs. mos. 3 wks. ds.

CONTRIBUTORY (Secondary) Intestinal Tuberculosis about 2 or 3 mo.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jno. H. Thompson M. D.

3/7, 1921 (Address) 1014 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Mar. 8 1921

20 UNDERTAKER Jno. McJohnson

ADDRESS 1234 Ellwing St

TION is very important. See instructions on ba

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

#51602 #51602 V 51602

CERTIFICATE OF DEATH.

10-091

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1758 E. North Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas H. Cofield

(Residence in Baltimore: No. 1758 E. North Ave, St.; 29 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Mar. 14, 1878 (Month) (Day) (Year)

7-AGE. 41 yrs. 11 mos. 24 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist for
(b) General nature of industry, business, or establishment in which employed (or employer): Ott Ld Co

9-BIRTHPLACE, (State or Country): Balto Co Md

PARENTS.

10-NAME OF FATHER: Edward Cofield

11-BIRTHPLACE OF FATHER (State or Country): Balto Co

12-MAIDEN NAME OF MOTHER: Charlotte Cole

13-BIRTHPLACE OF MOTHER (State or Country): Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Fannie Cofield

(Address) 1758 E. North Ave

15-Filed MAR 8-1921, 191.... BOREE? & KRAUTER Burial Permit Reg....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8th, 1921 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from March 2 1921, to March 8 1921, that I saw h[im] alive on March 7 1921, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Thomas H. Mayer M. D.

3/8, 191.1 (Address) 103 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Pleasant View Balto Co

DATE OF BURIAL, Mar. 10, 1921

20-UNDERTAKER A. Marshall

ADDRESS 358 Fulton Ave

CAUSE OF DEATH. See instructions on back of certificate. important.

D51603 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore

CITY OF BALTIMORE (No. General Hospital. ST.: 23 172 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Norval McCarty.

(Residence in Baltimore: No. 117 McComas Street.West St.; 12 yrs., ---------- mos. ---------- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH, ...July 20th, 1872...., 1..... (Month) (Day) (Year)

7-AGE, ...48...yrs....7....mos....14....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Wreck foreman
(b) General nature of industry, business, or establishment in which employed (or employer)..... W.M.R.R. 073

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Charles McCarty.

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Alice Anderson.

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary B.McCarty (wife).....

(Address).....117 W?McComas Street.

15- Filed MAR 8-1921 ....., 19.... DOLLY F KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...March 6th, 1921....., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an....inquiry..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) inquiry.....find that said deceased came to.....his.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Fracture of the skull.....
Accidental fall down cellar steps.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) .....yrs.....mos.....ds.

(Signed) H. M. Leonhardt M. D. (Coroner.)

Mar. 7th., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
117 W. McComas St.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	3/9....., 1921
20-UNDERTAKER	ADDRESS
J. F. McCully	130 E. Fort

N. B.—Every item of information should be carefully considered, that it may be properly classified. Exact statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51604 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51604

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 303 N Bruce ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marshal Carter

(a) RESIDENCE. No. 303 N Bruce ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Mulatto	M

5a If married, widowed or divorced HUSBAND of (or) WIFE of Bertha Carter

6 DATE OF BIRTH (month, day, and year) 1873.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Cement

(c) Name of employer Mono

9 BIRTHPLACE (city or town) (State or country) America Va

PARENTS

10 NAME OF FATHER John Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Amelia Co Va

12 MAIDEN NAME OF MOTHER Missouri Haden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Amelia Co

14 Informant Leroy Carter

(Address) 1313 Mosher St

15 Filed MAR 8-1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-6 19 21

17 I HEREBY CERTIFY, That I attended deceased from 2-21, 19 21, to 3-6, 19 21

that I last saw h alive on 3-5-21, 19 21,

and that death occurred, on the date stated above, at 11.55 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Plow & Levy

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical symptoms

(Signed) Walter J. Travers, M. D.

19 (Address) 1618 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	March 8 1921
20 UNDERTAKER	ADDRESS
Daniel Easton	916

Mation should be carefully answered, so that it may be properly classified. Exact statements of CAUSE OF DEATH in plain terms

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51605 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51605

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 943 S. Paca ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gregory Avara

(a) RESIDENCE. No. 943 S. Paca ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Avara

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 845

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vincent Avara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Maggio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs. M. A. Avara
(Address) ~~943 S. Paca St~~

15 Filed MAR 8-1921 19 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 6, 1921, that I last saw him alive on March 6, 1921, and that death occurred, on the date stated above, at 10 10/60 m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Joseph L. Uchenbrenner M. D.

Mar. 8 1921 (Address) 2 W. Mt. Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	March 9 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S. Paca St

CAUSE OF DEATH must be filled in by physician. TION is very important. See instructions on back of certificates.

D.51606 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1335 James St.; 21 WARD) REGISTERED No. C 94

2-FULL NAME Charles G. Kilby

(Residence in Baltimore: No. 1336 James St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Nov (Month) 4 (Day), 1920 (Year)

7-AGE, ...yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Robert Kilby

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Viola McAmuel

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola M Kilby

(Address) 1335 James St

15- Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit, Clerk.

MAR 8 1921

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy of inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebro Congestion 3 days

..... (Duration) ....yrs. ....mos. 6 hrs.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) James M Fenton M. D. (Coroner.)

Mar 8, 1921. (Address) 706 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	March 9 1921
20-UNDERTAKER	ADDRESS
James L Wagner & Son	1002 Pennsylvania Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51607 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51607

CERTIFICATE OF DEATH. 150

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Taylor.

(a) RESIDENCE. No. 352 Woodyear st ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) J. H. H. Records

15 Filed ..... 19 ..... Registrar

MAR 8-1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1921, to March 3, 1921, that I last saw h.. alive on March 3, 1921, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

Congenital Malformation of pan

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) W Boarman, M. D.

3-4, 1921 (Address) J H H Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS MAR 7 1921

Commissioner Health,

Per. Wm. E. WOODALL

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.51608 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 5 WARD) 24

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Kelly

(a) RESIDENCE. No. 508 East St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Five mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 8 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	-	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Willie White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Josephine Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record
(Address) J H H

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1921, to March 2, 1921, that I last saw him alive on March 2, 1921, and that death occurred, on the date stated above, at 10.00 P. m.

The CAUSE OF DEATH* was as follows:

Tetany

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Electrical reaction

(Signed) ~~J H H~~ W. Davison M. D.

3-5 1921 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAR 7 - 1921

20 UNDERTAKER: Commissioner Health,

ADDRESS

For Wm. E. Woodall

R 8-1921

(See instructions on back of certificate. This is very important.)

Spec.—6-9-19—H. P. Co.—1000 Blks.

20 51609 HEALTH DEPARTMENT—CITY OF BALTIMORE 20 51609

CERTIFICATE OF DEATH. 18

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Petrucci

(a) RESIDENCE. No. 1202 Eough St ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Dominik Petrucci

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Agnina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Record
(Address) J. H. H.

15 Filed Robert P. Harrison, Registrar

R 8 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 - 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3 1921, to March 4 1921, that I last saw h... alive on March 4 1921, and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? None

(Signed) W. E. Dawson, M. D.

3-5, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS MAR 7 - 1921
Commissioner Health,	
Per Wm E. WOODALL	

TION is very important. See instructions on back of certificate.

Spec.—6-9-12—H. P. Co.—1000 Blks.

20.51610 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51610

140

CERTIFICATE OF DEATH.

91-152

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Franklin

(a) RESIDENCE. No. 12 E Chester St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Byland Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Theresa Willett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Board J. H. H.

15 Filed MAR 8-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 4 1921, to March 4, 1921, that I last saw h[illegible] alive on March 4, 1921, and that death occurred, on the date stated above, at 3 00 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
Atelectasis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C W Dawson, M. D.

3-5, 1921 (Address) J H H Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAR 7 - 1921

20 UNDERTAKER Commissioner Health,
ADDRESS

Rev. Wm. E. WOODALL

CAUSES OF DEATH. See instructions on back of certificate. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51611 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51611

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3710 E Pratt ST. 2d WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie M Walden

(a) RESIDENCE. No. 3710 E Pratt ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Walden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Minnie Bessey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Minnie Walden 3710 E Pratt

15 Filed MAR 8-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from 12/20 1920, to March 7 1921, that I last saw her alive on March 6 1921, and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum Exam

(Signed) C. A. Reifschneider, M. D.

3/7, 1921 (Address) 340 S East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Mon	10 1921
20 UNDERTAKER	ADDRESS
W. M. Cook Co & Mallon	

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51612 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 W. Barre St. 27 WARD) REGISTERED NO. C 92

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annetta Colletti

(Residence in Baltimore: No. 547 W. Barre st St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, December 8, 1885
(Month) (Day) (Year)

7-AGE, 35 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy.

PARENTS.

10-NAME OF FATHER, Vincenzo Guerisi

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER M. Scavaggo.

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Guerisi

(Address) 547 W. Barre st.

15-

Filed MAR 8 1921 Robert P. Harrison Registrar.

Burial Permit Clerk.

important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 7 st, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1 st 1921, to March 7 st 1921, that I saw h[er] alive on March 7 st 1921, and that death occurred, on the date stated above, at 12.15 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. Testa M. D.

, 191... (Address) 2101 East 7th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. dc. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	March 9, 1921

20-UNDERTAKER George J. Ruth ADDRESS 1735 Hayford ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51613 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51613

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Carrigan

(a) RESIDENCE. No. 1806 No. Calvert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence if city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 26 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James Carrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Sophia Whitaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Winton Carrigan (Address) 4320 48th New York Ave

15 Filed MAR 8 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1921, to March 7, 1921, that I last saw him alive on March 7, 1921, and that death occurred, on the date stated above, at 3.05 p.m.

The CAUSE OF DEATH* was as follows:

Septicaemia Streptococcus Viridans.

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumonia - con.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) Wm H Pearce, M. D.

, 19 (Address) 205 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 9, 1921
20 UNDERTAKER George J. Smith	ADDRESS 1000 N Eutaw St

CAUTION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51614 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51614

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Southern Ave (Gardenville) ST.; 5 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Steigerwald Jr.

(Residence in Baltimore: No. (Gardenville) St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	W	S

6-DATE OF BIRTH, Nov. (Month) 17 (Day), 1921 (Year).

7-AGE, ...yrs. 3 mos. 19 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Gardenville Md

PARENTS.

10-NAME OF FATHER, Charles Steigerwald

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER R. Hertzig

13-BIRTHPLACE OF MOTHER (State or Country), Wilmington

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E. Steigerwald

(Address) 21 Southern Ave

15- Filed MAR 8 1921, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....X....191....., to ....X....191.....,
that I saw h..... alive on .....191.....,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

Tetanus Pneumonia (over)

(Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Benton A. Frat M. D.

3/8, 1921. (Address) Camden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Pk	3/10, 1921
20-UNDERTAKER	**ADDRESS**
J. F. McCully	130 E Ford

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 46682 D. 51615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51615

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lois Miller

(a) RESIDENCE. No. 3600 Chestnut Av ST. Balto ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23rd 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2 1/2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Vernon Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Edith Armistead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Frd. Friends

15 Filed MAR 8-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7- 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1921, to March 7-, 1921, that I last saw h alive on March 7-, 1921, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Acute catarrhal jaundice

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Hemorrhages

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	March 9 1921
20 UNDERTAKER	ADDRESS
Horace Burgee & Son	3600 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omissions will delay the registration of certificates. TION is very important. See instructions on back of certificates.

D.51616 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51616

CERTIFICATE OF DEATH 167

1-PLACE OF DEATH: Mercy Hospital

CITY OF BALTIMORE (No. ~~400 Fawcett~~ St.: 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Sarah Ford

(Residence in Baltimore: No. 1400 Fawcett St.; yrs., 80 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Aug. (Month) 3 (Day), 1836 (Year)

7-AGE: 84 yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country): Montgomery Co. Md

PARENTS.

10-NAME OF FATHER: Wm. Nichols

11-BIRTHPLACE OF FATHER (State or Country): Scotland

12-MAIDEN NAME OF MOTHER: Elizabeth Gibson

13-BIRTHPLACE OF MOTHER (State or Country): Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mrs. Bertha Hitchcock

(Address): 430 N. 23rd. St.

15- Robert P. Harrison,

Filed MAR 8 1921, 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: March 7 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bursa Gravel

Ignition from Gas-Stove

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) None

(Duration) ....yrs. ....mos. ....ds.

(Signed) ....M. D.
(Coroner.)

March, 1921 (Address) 1037 E. Fay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: March 10, 1921

20-UNDERTAKER: Horace Burgee Son — ADDRESS: 3631 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be understood by all. Every item important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51617 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51617

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Alvin Mc. Farland

(a) RESIDENCE. No. 1131 Carroll ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila Pa.

PARENTS

10 NAME OF FATHER William E. Mc Farland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lyda D. Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) William E. Mc Farland 1131 Carroll St.

15 FILED MAR 8 1921 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6th, 1921, to March 7th, 1921, that I last saw him alive on March 7th, 1921, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1131 Carroll St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wade E Trempler, M. D

, 19 (Address) 1013 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Centreville Md	Mar 8 1921

20 UNDERTAKER	ADDRESS
Mr & Mrs John H. Teufel & Son	801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51618 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51618

CERTIFICATE OF DEATH. 192

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 25 WARD)

2-FULL NAME Albert Kelly

(a) RESIDENCE. NO. Mt. St. Josephs College ST., WARD. Richmond Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17 yrs.	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. V. City, W. Va

PARENTS

10 NAME OF FATHER David H. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary F. White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant David H. Kelly (Address) Mt. St. Joseph College

15 Filed MAR 8-1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1921, to 3-8, 1921, that I last saw him alive on 3-8, 1921, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Double Lobar

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L Livingston M. D.

19 (Address) Prognosis.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montclair N. J.

DATE OF BURIAL Mar 9 1921

20 UNDERTAKER F. A. Krouse & Son

ADDRESS 703 Hanover

TION is very important. See instructions on back of Certificate

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.51619 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51619

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 So Third ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hagen

(a) RESIDENCE. NO. 423 So Third ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John B. Hagen

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) " " "

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Philip Haschert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John. F Hagen
(Address) 423 So 30 St

15 Filed Robert P. Harrison, Registrar

AR 8-1921 Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1920, to Mch 6, 1921,

that I last saw her alive on Mch 6, 1921,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma
exhaustion

(duration) X yrs. X mos. 21 ds.

CONTRIBUTORY (Secondary) Chronic Bright's disease (duration) 1 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same

(Signed) Jas. L. Imaw, M. D.

Mch. 8, 1921 (Address) 248 So 30 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Mch 9, 1921
20 UNDERTAKER	ADDRESS
Arnold Humphreys	37 Lexington St

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

Form.—6-9-19—H. P. Co.—1000 Blks.

D51620 HEALTH DEPARTMENT—CITY OF BALTIMORE D51620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 N. Caroline ST.: 6 120 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theressa Brown

(a) RESIDENCE. NO. 21 N Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widowed

5a If married, widowed, or divorced
(or) WIFE of Thomas Brown

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's Co
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Watts

11 BIRTHPLACE OF FATHER (city or town) St. Mary's Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Wolters

13 BIRTHPLACE OF MOTHER (city or town) St. Mary's Co
(State or country) Md.

14 Informant Mary Bird (sister)
(Address) 21 N. Caroline St.

15 Filed MAR 9-1921 [illegible] Registrar
Burial Permit Clerk

CAUSE OF DEATH ... TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/4, 1921, to 3/6, 1921, that I last saw h[illegible] alive on 3/6, 1921, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary Exam. + Physical

(Signed) Ralph J. Young, M. D.

3/7, 1921 (Address) 1416 Jefferson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 19 21

20 UNDERTAKER Mrs Robert A Elliott ADDRESS 1735 Hilland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51621

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51621

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Warner ST.: 21 WARD)

2-FULL NAME Annie Carter

(a) RESIDENCE. NO. 914 Warner ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Addison Welty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susan Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Blanche Carter
(Address) 914 W Warner

15 MAR 9-1921 ROBERT P. LAMPTEY Registrar
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to March 7, 1921, that I last saw h[illegible] alive on March 6, 1921, and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows: Cardiac Asthma Calculus

(duration) yrs. 5 mos. 22 ds.

CONTRIBUTORY (Secondary) Dr Theresa (duration) yrs. 5 mos. 22 ds.

18 Where was disease contracted if not at place of death? 914 Warner

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. B. Harris, M. D.

, 19 (Address) 712 S. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mch 10 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Ostend St

TION is very important. See instructions on back of certificate.

Size 6-9-19—H. F. Co.—1000 Blks.

D51622 HEALTH DEPARTMENT—CITY OF BALTIMORE D51622

CERTIFICATE OF DEATH. 79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 220 N Amity ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary King

(a) RESIDENCE. NO. 220 N Amity ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col'd	Wid.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Wilkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edna Porter

(Address) 220 N Amity St

15 Filed MAR 9 - 1921 19 ROBERT F. LEUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1921

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1921, to Mar 7, 1921,

that I last saw h... alive on March 7, 1921,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Mch 9, 1921 (Address) 739 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mount auburn Cemetery	March 9 1921

20 UNDERTAKER John H Toadvine ADDRESS 142 N Hill St

CAUSE OF DEATH.—See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51623 HEALTH DEPARTMENT—CITY OF BALTIMORE D51623

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 S Sharp ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Hill

(a) RESIDENCE. NO. 909 S Sharp ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unoccupied

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Winker Sorrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Florence Spriggs (Address) 909 S Sharp St

15 Filed MAR 9-1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/1 1921, to 3/6 1921, that I last saw h.. alive on 3/6 1921, and that death occurred, on the date stated above, at 4.03 P m.

The CAUSE OF DEATH* was as follows:

Anemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Subacute Parenchymatous (Colds & Influenza) (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Tim Bowlay, M. D.

3/7 1921 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mch 9 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Light St

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

(Maggie Plytnikene) D 51624

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51624

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 137

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Green & Lombard Sts ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs M. Plytnikase Plytnikene

(a) RESIDENCE. NO. 731 W. Lexington ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 12 yrs. ~ mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Moxow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Moxow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant (Address) J. Plytnikas 731 W Lexington St.

15 Filed MAR 9 - 1921 19 ..... Registrar

Burial Permit Clerk

TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to March 8, 1921, that I last saw her alive on March 8, 1921, and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia.

..... (duration) ... yrs. ... mos. 16 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? YES Date of March 5-1921

Was there an autopsy? .....

What test confirmed diagnosis? Blood Culture

(Signed) Jos Hundley Jr. , M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 10 1921

20 UNDERTAKER ADDRESS

John Grebliunas 426 S. Pac

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51625 HEALTH DEPARTMENT—CITY OF BALTIMORE D51625

CERTIFICATE OF DEATH

102

1-PLACE OF DEATH — Hospital

CITY OF BALTIMORE: (No.) Volunteers of America (ST.) 15 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil Goutrain

(a) RESIDENCE. No. 1727 N. Fulton ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Goutrain

6 DATE OF BIRTH (month, day, and year) March 26, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	11	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — Make-up of Forms
(b) General nature of industry, business, or establishment in which employed (or employer) — Evening Sun
(c) Name of employer — A. S. Abell Co.

9 BIRTHPLACE (city or town) (State or country) — Bayern Germany

PARENTS

10 NAME OF FATHER — Robert Goutrain

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Germany

12 MAIDEN NAME OF MOTHER — Helen Neuschaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Germany

14 Informant — Anna M. Goutrain
(Address) 1727 N. Fulton

15 MAR 9 1921 — ROBERT J. LAUTER Registrar — Social Forms Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1921, to March 8, 1921, that I last saw h.im alive on March 8, 1921, and that death occurred, on the date stated above, at 12. 40 a.m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Edema of the Lungs

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death? 1727 N. Fulton ave

Did an operation precede death? Yes Date of March 4-21

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. L. Tayanall, M. D.

, 19 (Address) 418 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	(Month) 10 1921
20 UNDERTAKER Zurkler & Zirkler	ADDRESS 1739 Eager

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51626 HEALTH DEPARTMENT—CITY OF BALTIMORE D51626

CERTIFICATE OF DEATH. 137

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rhoda Holland

(a) RESIDENCE. NO. Hillsdale, Md. ST., WARD. Hillsdale Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Chas. D. Holland

6 DATE OF BIRTH (month, day, and year) Oct. 1, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Evelyn Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Chas. D. Holland (Address) Hillsdale

15 FILED MAR 9 - 1921 ROBERT A. KLAUSER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/7, 1921, to 3/8, 1921, that I last saw h.. alive on 3/8, 1921, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Infection

(duration) yrs. mos. 1 4 ds.

CONTRIBUTORY (Secondary) Cervical Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/7/21

Was there an autopsy? Laparotomy

What test confirmed diagnosis?

(Signed) Lewis O. Ridgely, M. D.

3/9, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 10 1921
20 UNDERTAKER Zickler & Zickler	ADDRESS 1734 Eager

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51627
43

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3937 Roland Ave ST.; 13 WARD)

2-FULL NAME Ellen Wells

(a) RESIDENCE. NO. 3937 Roland Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word)
F	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas Wells Dec 15-1834

6 DATE OF BIRTH (month, day, and year)	Years	Months	Days	If LESS than 1 day, hrs. or min.
7 AGE	86	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 86
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Md
10 NAME OF FATHER William Lackey
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Margaret Brawner
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mark Wells
(Address) 3920 Eastern Ave

15 Filed MAR 9-1921 ROBERT I. CRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 21 1921, to March 7, 1921, that I last saw h[illegible] alive on March 7, 1921, and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam.

(Signed) R B Nowend M. D.
3-8 1921 (Address) 3542 Chelsea Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden DATE OF BURIAL March 10 1921

20 UNDERTAKER Chenowith & Son ADDRESS 10 Chestnut Ave

D 51628

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 51628

CERTIFICATE OF DEATH

1 PLACE OF DEATH — Woodberry — REGISTERED NO. C 120

CITY OF BALTIMORE (No. 3620 Central ave ST. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME David C. Hubbs.

(Residence in Baltimore: No. 3620 Central ave, St.; 20 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
male	White	Married

6 DATE OF BIRTH — July (Month) 10 (Day), 1853 (Year)

7 AGE — 67 yrs. 7 mos. 26 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: watchman 062
(b) General nature of industry, business, or establishment in which employed (or employer): Cotton Duck mill

9 BIRTHPLACE (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Charles Hubbs

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Madela Shontz

13 BIRTHPLACE OF MOTHER (State or country): Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice J. Hubbs

(Address) 3620 Central Ave

15 MAR 9-1921 Filed ....., 191 — [illegible] REGISTRAR — Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH — March (Month) 8 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1921, to Mar 8 1921, that I saw him alive on Mar 8, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) Chr. Valv. Heart. Disease

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) [illegible], M. D.

3/8, 1921 (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: Mar 10, 1921

20 UNDERTAKER: Chenoweth & Son — ADDRESS: Westminster

N. B.—Every CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stamp.—5-9-19—H. P. Co.—1000 Rks.

D51629

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51629

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 Calvin ST.: 5 WARD)

2-FULL NAME Charles Chase

(a) RESIDENCE. No. 112 Calvin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hatty Chase

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hatty Chase
(Address) 112 Calvin St.

15 MAR 9-1921 ROBERT J. KRAFFT Registrar
Burial Permit Obtd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22 1920, to Mar 7, 1921, that I last saw him alive on March 7, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? exam. of urine

(Signed) Robt J Green M. D.

3-8, 1921 (Address) 120 1/2 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	March 10 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

CAUSE OF DEATH. Physician will please fill out this page. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51630

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51630

CERTIFICATE OF DEATH.

REGISTERED NO. 2479

1-PLACE OF DEATH US. Public Health Hospital #56

CITY OF BALTIMORE: (NO. Fort McHenry ST.) Baltimore Md. WARD) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas W. Falloudown.

(a) RESIDENCE. NO. US Public Health Hospital #56 ST. WARD. 26

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Roseburr Registrar.

(Address) U. S. PUB. HOSP. FORT [illegible] BALTIMORE.

15 Filed MAR 9 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1920, to Mar. 8, 1921, that I last saw him alive on Mar. 8, 1921, and that death occurred, on the date stated above, at 3'10 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic acute failure of compensation.

--- (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Thomas W. Payne Senior Surgeon M. H.

, 19 (Address) US. PH. Hosp. #56 Ft. McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Mar 9 1924

20 UNDERTAKER S. Levinson & Bro.

ADDRESS 127 E Balto St

TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51631 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51631

CERTIFICATE OF DEATH.

79 REGISTERED NO.

1-PLACE OF DEATH Brooks Lane & Eutaw Place

CITY OF BALTIMORE: (No. Esplanade Apt ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Schloss

(a) RESIDENCE. No. Esplanade Apt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Schloss

6 DATE OF BIRTH (month, day, and year): April 6th 1839

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
81	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Hirshinger
(Address) 9 Esplanade Apt

15 Filed MAR 9 - 1921 ROBERT J KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 6th, 1905, to March 7th, 1921, that I last saw her alive on March 7th, 1921, and that death occurred, on the date stated above, at 9:10 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (Coronary artery thrombosis)

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis; mitral insufficiency (duration) 16 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

III 8, 1921 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rest Haven	Mch 1921
20 UNDERTAKER	ADDRESS
Harry Goodheim	148 N. Eutaw St

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D51632

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51632

CERTIFICATE OF DEATH.

10-091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 N. First St. Brooklyn WARD) 5

2-FULL NAME George Koenig

(a) RESIDENCE. No. 36 N First St. Brooklyn WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Koenig

6 DATE OF BIRTH (month, day, and year) Oct 12 1879

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
41	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store room keeper

(b) General nature of industry, business, or establishment in which employed (or employer) for

(c) Name of employer Copper and Iron Works Curtis Bay

9 BIRTHPLACE (city or town) Balto (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo Koenig

11 BIRTHPLACE OF FATHER (city or town) France (State or country) France

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know, (State or country) Germany

14 Informant Mrs Mary E Koenig (Address) 36 N First St Brooklyn Md

15 MAR 9- 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 1, 1921, to Mch 8, 1921, that I last saw h alive on Mch 7th, 1921, and that death occurred, on the date stated above, at 4.15 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) 7 yrs 0 mos. 10 ds.

18 Where was disease contracted if not at place of death? Locher

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys Signs

(Signed) H Wilmuth, M. D.

, 19 (Address) 1348 Locust

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	March 11 1921
20 UNDERTAKER John F Denny	ADDRESS 715 Light

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51633

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 Filbert. ST., Curtis Bay WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julianna Schramm

(a) RESIDENCE. No. 101 Filbert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C Schramm

6 DATE OF BIRTH (month, day, and year) June 9, 1836

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Petersburg Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Schramm (Address) 1519 N Bethel st.

15 MAR 9-1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to Mar 7, 1921, that I last saw h— alive on Mar 8, 1921, and that death occurred, on the date stated above, at 9 15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Chas H Brooks, M. D.

Mar 9, 1921 (Address) 1-3-51 Brooks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL March 10 1921

20 UNDERTAKER John F Denny

ADDRESS 715 Light st

CAUSE OF DEATH ... See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

051634 HEALTH DEPARTMENT—CITY OF BALTIMORE 051634

CERTIFICATE OF DEATH. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen. Hospital WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie Winston

(a) RESIDENCE. No. 713 Hanover ST., WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct. 14. 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Winston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Page

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) South Balto Gen. Hospital 1213 Light St.

15 MAR 9 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 2, 1921, to Mar 6, 1921, that I last saw him alive on Mar 6, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation (syphilitic)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted? If not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Howard Y. Tolson M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cmty	Mar 9 1921
20 UNDERTAKER	ADDRESS
George H. Holland	162 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Frances Lacanare

D 51635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51635

9

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1512 Ramsay St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Lacanare

(a) RESIDENCE. No. 1512 Ramsay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John Lacanare

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Marino

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Rose Lacanare
(Address) 1512 Ramsay St.

15 MAR 9-1921 ROBERT I KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h.....alive on ....., 19.....,

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

.....(duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY
(Secondary)

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Ruff, M. D.

, 19 (Address) H. 1. 19th Ward.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents Cemetery	Mar 9 21

20 UNDERTAKER	ADDRESS
Harry H. Witzke	1631 W Lanvale

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

051636

HEALTH DEPARTMENT—CITY OF BALTIMORE

051636

CERTIFICATE OF DEATH.

152

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 862 Lyndon St.; 11 WARD)

2-FULL NAME Bobby Crumpton

(Residence in Baltimore: No. 862 Lyndon St.; .....yrs., ...mos. .....ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March 8th, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or 7 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Joseph Crumpton

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Susie Turner

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie Crumpton

(Address) 862 Lyndon St.

15- Filed MAR 9-1921 BOBBY J KRAUTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8th, 1921
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 8th, 1921, to March 8th, 1921, that I saw h— alive on March 8th 1921, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Delayed Labor

Birthfeed Cord

.....

.....

.....
(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

.....
(Duration) .....yrs. .....mos. .....ds.

(Signed) A. Peter Ellis M. D.

3/9/, 1921 (Address) 22 W. Mt. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, MAR 9 1921

20-UNDERTAKER Commissioner Health,

ADDRESS

Per. Wm. E. WOODALL

Important. See instructions for filling out this certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-51637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-51637

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital (Ward)

2-FULL NAME Mrs Jane Micholland

(a) RESIDENCE. No. 319 S. Woodyear Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dallas

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Augusta E. Hack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. J. Micholland
(Address) 319 S. Woodyear St.

15 Filed MAR 9 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/4, 1921, to 3/6, 1921, that I last saw h[illegible] alive on 3/6, 1921, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) J. Frungton, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March 9 1921
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Fayette St

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D51638 HEALTH DEPARTMENT—CITY OF BALTIMORE D51638

64

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Rutland ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Epps

(a) RESIDENCE. No. 1217 Rutland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? Wh yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Mar.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 50 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Housework
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mark Epps
(Address): 1217 Rutland St

15 FILED MAR 9-1921 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1921, to March 7, 1921, that I last saw h alive on March 7, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

March 8, 1921 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: March 10th 1921

20 UNDERTAKER: A Jones — ADDRESS: 207 S Stricker St

TION is very important. See Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

951639 HEALTH DEPARTMENT—CITY OF BALTIMORE 951639

CERTIFICATE OF DEATH.

91-089

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1747 E Lafayette Ave ST.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hasselbacher Jr

(Residence in Baltimore: No. 1747 E Lafayette Ave St.; 5/12 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 14, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 8 mos. 22 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Hasselbacher

11-BIRTHPLACE OF FATHER (State or Country), Phila Pa

12-MAIDEN NAME OF MOTHER Nettie E White

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hasselbacher

(Address) 1747 E Lafayette Ave

15- MAR 9-1921 ROBERT J KRAUTER
Filed ....., 191... Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from mar 6, 1921, to mar 8, 1921, that I saw h[illegible] alive on mar 8, 1921, and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) [illegible] M. D.

Mar 9, 1921 (Address) 1200 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dan Lamb Cemetery — DATE OF BURIAL, Mar 10 1921

20-UNDERTAKER Robt J Krauter — ADDRESS 1x42 N Bway

Important. See instructions on reverse side.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

251640 251640 150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 619 S. Bethel ST.; 7 WARD)

2-FULL NAME Wladyslaw. Kaspszyk

(a) RESIDENCE. NO. 619 S. Bethel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) Feb. 6 - 21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wladyslaw. Kaspszyk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary. Drolinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wladyslaw. Kaspszyk.
(Address) 619 S. Bethel st.

15 MAR 9 - 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 8, 1921,

that I last saw him alive on March 8, 1921,

and that death occurred, on the date stated above, at 1 AM. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Trouble

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Rysanek, M. D.

3/8/21 19 (Address) 801 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	Mar. 9 1921

20 UNDERTAKER Wm Fiallkowski 1618 ADDRESS Eastern Ave.

TION is very important. See Instructions on Back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51641 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51641

CERTIFICATE OF DEATH.

REGISTERED NO. 792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3226 Donnell St.; No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kunigunda Gemmer

(a) RESIDENCE. No. 3226 Donnell St., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Gemmer

6 DATE OF BIRTH (month, day, and year) Apr. 1, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna J. Gemmer
(Address) 3226 Donnell

15 Filed MAR 9-1921 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 5, 1921, to Mch 6, 1921, that I last saw her alive on Mch 6, 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Contusion
+ Bronchitis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated heart (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M. J. McAvoy, M. D.

3/8, 1921 (Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	March 9 1921
20 UNDERTAKER Lilly & Ed Zeiler	ADDRESS 403 S. Wolfe St

TION is very important. See instructions on back of Certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51642 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51642

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 E Barney ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Tichnell

(a) RESIDENCE. NO. 31 E Barney ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Tichnell

6 DATE OF BIRTH (month, day, and year) July 15th 1853

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine McHeath

(Address) 31 E Barney st

15 Filed 19 Robert P. Harrison, Registrar

9-1921 Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1924, to March 7, 1924, that I last saw her alive on March 6, 1924, and that death occurred, on the date stated above, at 7.20 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) J. H. Harrison M. D.

3/9, 1924 (Address) 16 E Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Mar 10 1924
20 UNDERTAKER	ADDRESS
B Schuman & Son	Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Drega)

20.51643 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51643

CERTIFICATE OF DEATH.

REGISTERED NO. 25-92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Drega.

(a) RESIDENCE. NO. St. Mary's Ind. School ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19 yrs.	9	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know
(b) General natore of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) Do not know
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Bro. Paul
(Address) St. Mary's Ind. School

15 Filed Robert P. Harrison, Registrar
3-9-1921 Burial Permit Clerk.

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8-1921

17 I HEREBY CERTIFY, That I attended deceased from 3-5, 1921, to 3-8, 1921, that I last saw him alive on 3-8-, 1921, and that death occurred, on the date stated above, at 11 40 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. M. Craig M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Mar 12, 1921
20 UNDERTAKER M. F. Sadoroski.	ADDRESS 705 S. Ann

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51644 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51644

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3834 Ashburton ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Minnie Moessinger

(a) RESIDENCE. No. 3834 Ashburton ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Moessinger

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Philip Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Waltmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs M. M. Smith (Address) 3834 Ashburton Ave.

15 Filed Mar 9-1921 Robert P. Harrison, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 5 1921, to Mar 7 1921, that I last saw her alive on Mar 7 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

3/9 1921 (Signed) J. F. Kirby M. D. (Address) 1102 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glen Rock Pa	3/10" 1921

20 UNDERTAKER Bart. Evans & Son ADDRESS 11 W Mt Royal Ave

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51640 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51645

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 867 Park Avenue or, 11th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Brown

(a) RESIDENCE. No. 867 Park Avenue or, 11th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Arthur George Brown

6 DATE OF BIRTH (month, day, and year) Dec. 30. 1844.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Francis West Ahrickes

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Elizabeth McElderry

13 BIRTHPLACE OF MOTHER (city or town) Piscataway (State or country) Md.

14 Informant Hunter F Brown (Address) 867 Park Ave.

15 Filed ... 19... Robert P. Harrison Registrar

R 9-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1921, to March 8, 1921, that I last saw her alive on March 8, 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

Chronic Interstitial Nephritis

(duration) 11 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hemiplegia over

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) A. D. Atkinson, M. D.

, 19 (Address) 1010 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	3-10 1921
20 UNDERTAKER	ADDRESS
Henry W Jenkins Sons Co	Richard McCulloh

TION is very important. See instructions on back

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

~~145799~~ D. 51646

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51646

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cate Curran

(a) RESIDENCE. NO. 207 N. Wolfe st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 8. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: C Field 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Sally

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Lavin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) J. H. H. Records

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

R 9-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1921, to March 8, 1921, that I last saw her alive on March 8, 1921, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage
to arterio-sclerosis Secondary

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Bronchi-pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry M. Thomas Jr., M. D.

38 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar. 10 1921

20 UNDERTAKER	ADDRESS
John A Moran	3000 E Balto.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Dr Burbert

D.51647

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51647

HEALTH DEPARTMENT—CITY OF BALTIMORE

40

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Ridgewood St. 15 WARD)

2-FULL NAME Philip Streifler

(a) RESIDENCE. No. 1912 Ridgewood St. 15 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city ~~or town~~) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Frank Reilly
(Address) 1912 Ridgewood St

15 Filed Robert P. Harrison, Registrar
9-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 11th, 1921, to Mch 8th, 1921, that I last saw h[illegible] alive on Mch 8th, 1921, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation preeede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. H. Burbert, M. D.

, 19 (Address) 1100 W. Laf. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Mar. 11 1921
20 UNDERTAKER	ADDRESS
Martin Fahey Sons	2827 W. North Ave

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51648 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51648

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2681 St Benedict ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul W Schmiedchen

(a) RESIDENCE. No. 2681 St Benedict ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
male	White	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Hedwig Schmidtchen

6 DATE OF BIRTH (month, day, and year) July 1, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Can Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Hedwig Schmidtchen (Address) 2681 St. Benedict St.

15 Filed MAR 9-1921 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1920, to March 7, 1921, that I last saw him alive on March 7, 1921, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Gustav Dill M. D.

3/9, 1921 (Address) 1433 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Mar. 10 1921
20 UNDERTAKER C. W. Dill.	ADDRESS 3109 Fredk Ave.

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51649 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51649

71

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3039 Huntington ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F. Smith

(a) RESIDENCE. NO. 3039 Huntington ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Lucie DeBill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Frank Smith
(Address) 3039 Huntington ave

15 Filed MAR 9 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1921, to March 8, 1921, that I last saw him alive on March 8, 1921, and that death occurred, on the date stated above, at 1130 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) Few hrs.

CONTRIBUTORY (Secondary) Scarlet fever

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. G. Richardson M. D.

(Address) 1122 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	March 1921
20 UNDERTAKER E. G. Wiedefeld Jr	ADDRESS 501 E 22 St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51650 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51650

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 529 Rositer ave. ST.: 27 WARD)

2-FULL NAME Mary E. Weyrich

(a) RESIDENCE. No. 529 Rositer Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Joseph J. Weyrich

6 DATE OF BIRTH (month, day, and year) June 24 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John B. Mooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Leah Weyrich (Address) 529 Rositer ave.

15 Filed Mar 9-1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 4 1921, to March 9, 1921, that I last saw h.. alive on March 9, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

1. Cerebral Hemorrhage
2. Chronic Nephritis
3. Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —— None

(Signed) J. E. Moran, M. D.

3/9 1921 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Mar 11 1921

20 UNDERTAKER: John A. Moran — ADDRESS: 3006 E. Balto St.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51651

CERTIFICATE OF DEATH.

10-0091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Notre Dame of Md. Charles ST.. 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aileen L. Halpin

(a) RESIDENCE. No. Thorton, Arkansas ST., WARD. Thorton Arkansas

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906-2-13

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Camden, Arkansas

PARENTS

10 NAME OF FATHER Bartholomew

11 BIRTHPLACE OF FATHER (city or town) Springfield (State or country) Minnesota

12 MAIDEN NAME OF MOTHER Harriet P. Storey

13 BIRTHPLACE OF MOTHER (city or town) Fort Dodge (State or country) Iowa

14 Informant Sister M. Philemon

(Address) Charles St. Ave.

15 Filed MAR 10 1921 ROBERT J. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1921, to Mar 8, 1921, that I last saw h alive on Mar 8, 1921, and that death occurred, on the date stated above, at 1:20 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenzal Broncho Pneumonia - and Nephritis (acute) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Claud Jones, M. D.

3/7, 1921 (Address) 4706 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Notre Dame Priv. Cem.	March 10
20 UNDERTAKER	ADDRESS
Frank A. Fink	910 N. Gay St.

CAUSE OF DEATH to be filled in plain terms. Abbreviations must not be used. Information is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 51652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51652

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Fallsway Road ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry C. Tyler

(Residence in Baltimore: No. 210 Fallsway Road St.; ... yrs., 11 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
M.	Col.	Single

6-DATE OF BIRTH, ... Apr. (Month) 3 (Day), 1920 (Year)

7-AGE.	If LESS than 1 day,
... yrs. 11 mos. 5 ds.	... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ———
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Tyler

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Lambert

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Tyler

(Address) 210 Fallsway Road

15- Filed MAR 10 1921, 19... ROBERT J. KRAUTER Burial Permit Clerk Registrar.

Important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 3 (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 3 1921, to Mar 7 1921, that I saw him alive on Mar 7 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

1. Bronchial Pneumonia

...

...

... (Duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY ... (Secondary)

... (Duration) ... yrs. ... mos. ... ds.

(Signed) C. H. Becker M. D.

3-8, 1921 (Address) 1711 Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Mar 10, 1921

20-UNDERTAKER	ADDRESS
Samuel T Hamilton	5750 Biddle

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51653

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp St. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Wilson

(a) RESIDENCE. No. 502½ Myrtle Ave ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 7 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jacob Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record
(Address) J. H. H.

15 Filed MAR 10 1921 ROBERT I. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 - 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 25 - 1921 to March 8 - 1921, that I last saw h alive on March 8 - 1921, and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Bacilli in sputum & autopsy

(Signed) Horton Casparis, M. D.

3-9, 1921 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar 11 1921
20 UNDERTAKER	ADDRESS
Samuel T Kemsley	578 N Eutaw

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51654

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18.S.Broadway ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Laird Gardner

(a) RESIDENCE. No. 18.S.Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or WIFE) of Mary Jane Gardner

6 DATE OF BIRTH (month, day, and year) Mch.26.1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	11	10	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk 604

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing supply House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Maryland

PARENTS

10 NAME OF FATHER Robert C.Gardner

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Susie Elliott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Robert C.Gardner

(Address) 18.S Broadway

15 Filed MAR 10 1921 ROBERT I. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1921, to March 9, 1921, that I last saw h— alive on March 9, 1921, and that death occurred, on the date stated above, at 9.40P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) A. F. Fiss, M. D.

Mch 9, 1921 (Address) 1 + S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Mch 11 1921
20 UNDERTAKER	ADDRESS
J. E. Hughes	424 S. Broadway

TION is very important. See instructions on back of certificate.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D51655 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D51655

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Harford Ave. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Booze

(a) RESIDENCE. No. 1709 Harford Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	widowed

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Harriet V.

6 DATE OF BIRTH (month, day, and year) Dec 16 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk. 009

(b) General nature of industry, business, or establishment in which employed (or employer) Baking dept

(c) Name of employer Maryland Biscuit Co

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James W. Booze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary E. Belcher.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Leonard V. Booze Sister
(Address) 1709 Harford Ave

15 Filed MAR 10 1921 ROBERT J. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 1, 1921, to Mar 8, 1921, that I last saw h. alive on Mar 8, 1921, and that death occurred, on the date stated above, at 8:10 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs & Coma (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic.

(Signed) J. Wallace Thomas M. D.

Mch 9 1921 (Address) 1228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Mch 10 1921

20 UNDERTAKER H. E. Hughes ADDRESS 432 N. Broadway

TION is very important. See instructions on back of certificate.

Stec.—8-24-14—M. & T.—2000 Bks.

D51656

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51656

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 Mosher ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank G. Duffield Jr.

(Residence in Baltimore: No. 1811 Mosher St. St.; 14 yrs., ... mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Mar. 5, 1907
(Month) (Day) (Year)

7-AGE, 14 yrs. ... mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank G. Duffield

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER Edith Fowler

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank G Duffield

(Address) 1811 Mosher St

15- MAR 10 1921 Filed ....., 191... BOARD OF HEALTH Baltimore Records

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21st 1920, to March 9th 1921, that I saw him alive on March 9th 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

..... (Duration) ... yrs. ... mos. 16 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Edward F. Evans M. D.

March 9th, 1921. (Address) 823 N. Futon Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
London Park	March 10, 1921.
20-UNDERTAKER	**ADDRESS**
John F. Lenny	715 Light St

Important. Use Indelible Pencil.

Spec.—6-9-19—H. P. Co.—1000 Bks.

951657

HEALTH DEPARTMENT—CITY OF BALTIMORE

951657

CERTIFICATE OF DEATH.

81

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1220 Greenmount Ave ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane A. Mooney

(a) RESIDENCE. No. 1220 Greenmount Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? 58 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas Mooney

6 DATE OF BIRTH (month, day, and year) Dec. 5 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Richard Ormond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. A. Rauh 1220 Greenmount Ave

15 Filed MAR 10 1921, 19.. ROBERT J. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from January 17th, 19 19, to March 8th, 19 21, that I last saw h.e.r alive on March 8th, 19 21, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Arteris-Sclerosis

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. days ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard E. Warden, M. D.

, 19 (Address) 530 E. South Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery Harford Road	March 11 1921
20 UNDERTAKER Henry Hoeck Son	ADDRESS 1301 E. Eager St

TION is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

951658 HEALTH DEPARTMENT—CITY OF BALTIMORE 951658

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.P.H.S. Hospital #56, REGISTERED NO. 45

CITY OF BALTIMORE: (No. Baltimore, Md.. St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George K. Marsh

(a) RESIDENCE. No. Ft. McHenry, Baltimore, Md.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower ~~Divorced~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Unknown Salome Marsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md Unknown Sarah E. Kilman Annapolis Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edgar T. Rowbotham Registrar.
(Address) U.S. PHS. Hosp. #56 Ft. McHenry Md.

15 Filed MAR 10 1921 ROBERT J. BAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1920, to Mar. 9, 1921, that I last saw him alive on Mar. 9, 1921 and that death occurred, on the date stated above, at 3.50 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Thomas B. Payne, M. D.

, 19 (Address) US. PHS. Hosp. #56 Ft. McHenry Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 12 1921
20 UNDERTAKER	ADDRESS
Henry Hoerl Son	1201 E Eager

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51659

HEALTH DEPARTMENT—CITY OF BALTIMORE

48 D51659

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (NO. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Evalena C. Kabernagel.

(a) RESIDENCE. NO. 21 Belmar, Raspeburg, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11th 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Kabernagel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Yellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John F Ogleman
(Address) Raspeburg Md

15 Filed MAR 10 1921 ROBERT J. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9th 1921

17

I HEREBY CERTIFY, That I attended deceased from March 3rd, 1921, to March 9th, 1921, that I last saw her alive on March 9th, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Osteoarthritis of hip, left

(duration) 35 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post-operative broncho-pneumonia with acute oedema of lungs. (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of March 4th, 1921.

Was there an autopsy? Partial.

What test confirmed diagnosis? Clinical course & autopsy.

(Signed) J. W. Chinery, Jr. , M. D.

March 10 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL. ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
London Park	Mon 12 1921
20 UNDERTAKER Geo W Little	ADDRESS 2700 Edmondson Ave

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

Seaman

D51660

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Windsor Mill St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie F Seaman

(a) RESIDENCE. No. 1805 Windsor Mill St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David F Seaman

6 DATE OF BIRTH (month, day, and year) Aug 24 1893

7 AGE 27 Years	Months	Days	If LESS than 1 day, hrs. or min.
27	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jacob S. Seaman

9 BIRTHPLACE (city or town) (State or country) Washington D. C

PARENTS

10 NAME OF FATHER Jacob S Seaman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C

12 MAIDEN NAME OF MOTHER Mary C Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Wm. S. Jules

(Address) 2950 Priestman St

15 MAR 10 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1921

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1921, to March 7, 1921, that I last saw h alive on " " 1921, and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Tobacco Intoxication

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Arthur C Kaer M. D.

3/9. 1921 (Address) 2600 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Mar 10 1921

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

TION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

D51661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51661

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 38 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McGuinness

(a) RESIDENCE. No. Mt Hope Retreat - ST. 28 WARD.

(Usual place of abode) as or over (25) (If nonresident give city or town and State) over 25 yrs.

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Don't Know yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow -

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Mr McGuinness

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
abt	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic - 70

(b) General nature of industry, business, or establishment in which employed (or employer) Kitchen Work -

(c) Name of employer Mt Hope Retreat

9 BIRTHPLACE (city or town) (State or country) Not Known Ireland -

PARENTS

10 NAME OF FATHER Henry McClear

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) Ireland -

12 MAIDEN NAME OF MOTHER Mary (?)

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Ireland -

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Baltimore Md -

15 FILED MAR 10 1921 COPIED

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 4th, 1921, to March 9th, 1921, that I last saw her alive on March 9th, 1921, and that death occurred, on the date stated above, at abt 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial)

abt (duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

March 9th 1921 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Mar 11/ 1921.
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51662

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mount Hope Retreat ST.: 25th WARD)

2-FULL NAME Bernard J. Conway

(a) RESIDENCE. NO. 225 W. 18th St. Phila Pa ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Born yrs. Here mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	68	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman - 018

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Work -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not Given - Ireland

PARENTS

10 NAME OF FATHER John J. Conway

11 BIRTHPLACE OF FATHER (city or town) Not Given (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret (Conway)

13 BIRTHPLACE OF MOTHER (city or town) Not Given - (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mount Hope Baltimore Md

15 MAR 10 1921 GEORGE J. RADCLIFF Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17 I HEREBY CERTIFY, That I attended deceased from July 17. 1915, to March 9 1921, that I last saw h[illegible] alive on March 9 1921, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis (R. Hemiplegia -) (Cerebral Hemorrhage)

(duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Chr Mania

abt (duration) 6 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa -

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glen Ruddle, Pa. DATE OF BURIAL Mar 11 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51663

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51663

CERTIFICATE OF DEATH.

10-04

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~Hawkins Point~~ ST.: ~~25~~ WARD)

2-FULL NAME William H. Jackson

(a) RESIDENCE. NO. Hawkins Point ST., 25 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? Yrs. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Eleanora Jackson

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Providence R.I.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Eleanora Jackson (Address) Hawkins Point

15 Filed MAR 10 1921 ROBERT I. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1921, to March 1, 1921, that I last saw h... alive on March 1, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos 27 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon S. Hess M. D.

, 19 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem. Md.	Mar. 11th 1921
20 UNDERTAKER	ADDRESS
Joseph A Farrell	2319 Division

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

146 38 D51664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51664

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Young

(a) RESIDENCE. NO. 820 North Spring st ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-2-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mamie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. H. Reuss

(Address)

15 MAR 10 1921 ROBERT P. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 - 1921

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to March 6, 1921, that I last saw him alive on March 6 -, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hospital Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	MAR 9 - 1921 19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, and state whether from Accident, Suicide or Homicide. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51665

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51665

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. H) Fort McHenry Baltimore Md. (WARD) 35

REGISTERED NO. 24 +28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A. Adams

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST. Fort McHenry WARD. Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) unknoown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tin smith

(b) General nature of industry, business, or establishment in which employed (or employer): ----

(c) Name of employer: ----

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknoow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Registrar US. Phs Hosp. #56 Ft. Mchenry Md.

15 MAR 10 1921 [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22 1920 19 , to Maroh 9, 1921.

that I last saw him alive on March 9, 1921, 19 .

and that death occurred, on the date stated above, at 3'45 a.m

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary active.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ----

Was there an autopsy? No

What test confirmed diagnosis? Exam. clinic report

(Signed) Thomas R. Paynes, M. D.

, 19 (Address) US. PHS. Hosp. #56 FT. Mchen Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Willmington Del	Mar 10 19 21
20 UNDERTAKER	ADDRESS 1127 E Balto St
[illegible] Sundrum & Bro	

TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

Jones

D 51666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51666

CERTIFICATE OF DEATH.

92-010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. North Ave & Kelly Ave ST.; 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon Bernard Jones

(Residence in Baltimore: No. North Avenue & Kelly Ave St.; 26 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
male	white	Single

6-DATE OF BIRTH, January 7, 1895
(Month) (Day) (Year)

7-AGE, 26 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... Balto City Court House

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John N. Jones

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER Jennie Kay

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin N. Jones

(Address) 2211 N. Calvert St. Balto. Md

15-
Filed MAR 10 1921, 191.... ROBERT I. KRAUTH
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 28 1921, to Mch 9 1921, that I saw him alive on March 9 1921, and that death occurred, on the date stated above, at 4.24 Am

The CAUSE OF DEATH* was as follows:

1 Influenza
(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
(Duration) yrs. mos. 8 ds.

(Signed) Wilbur J. Todd M. D.

3/9, 1921 (Address) 1 W. Washington Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, March 11 1921

20-UNDERTAKER John Ottenstein ADDRESS 120 W. Fayette

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D51667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D51667

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Beechfield ave, ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Dyson Hopkins

(Residence in Baltimore: No. Beechfield ave & Frederick Road St.; 73 yrs., 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Feb 27, 1848 (Month) (Day) (Year)

7-AGE, 73 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Hat Mf
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John L. Hopkins

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan Dyson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabel Luke Hopkins

(Address) Beechfield ave

15- MAR 10 1921 Filed....., 191.... ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 15th 1920, to March 8th 1921, that I saw him alive on March 7th 1921, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland and surrounding tissue

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Hemiplegia

(Duration) yrs. mos. 1 ds.

(Signed) J. Chas. Macgill M. D.

March 9th 1921. (Address) Calvert & St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, Mch. 10, 1921.

20-UNDERTAKER John O. Mitchell ADDRESS 201 N. Fayette St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51668 — 1162 — D 51668

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Keyser ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Fisher

(Residence in Baltimore: No. 1601 Keyser st St.; 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, November 22, 1854 (Month) (Day) (Year)

7-AGE, 66 yrs. 3 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bremen, Germany

PARENTS.

10-NAME OF FATHER, Andrew Fisher

11-BIRTHPLACE OF FATHER (State or Country) Bremen, Germany

12-MAIDEN NAME OF MOTHER Mary Fischer

13-BIRTHPLACE OF MOTHER (State or Country), Bremen, Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Silverzahn

(Address) 1601 Keyser st

15- FILED MAR 10 1921 191.. ROBERT J. KRAUPP REGISTRAR. SEPTIC POINT DIST.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8, 1921 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from February 25 1921, to March 8 1921, that I saw her alive on March 8 1921, and that death occurred, on the date stated above, at 10:35 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion - Cardiac Failure
Chronic constipation - Intestinal hemorrhage
(Duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary) Chronic degenerative
Cystitis (Duration) yrs. mos. 12 ds.

(Signed) William H. Schwartz M. D.
March 8., 1921. (Address) 1200 N. Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery — DATE OF BURIAL, March 10 1921

20-UNDERTAKER George J. Ruth — ADDRESS 1735 Hayford Ave.

Important. See instructions on this

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51669

CERTIFICATE OF DEATH.

15-79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 W. North Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Ziegler

(a) RESIDENCE. No. 2138 W. North Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Ziegler

6 DATE OF BIRTH (month, day, and year) Dec. 29 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick
(State or country) Md.

PARENTS

10 NAME OF FATHER David H. Haller

11 BIRTHPLACE OF FATHER (city or town) Frederick
(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza M. Roelke

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Daisy I. Ziegler
(Address) 2138 W. North Ave.

15 MAR 10 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 7" 19 21

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 7, 1921, that I last saw h alive on March , 1921, and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumo

(duration) mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A Evans, M. D.

3/8, 1921 (Address) 16 N Carey.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Mch 10 1921
20 UNDERTAKER	ADDRESS
Jos B Cook	Jos B Cook

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 51670

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51670

CERTIFICATE OF DEATH.

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1944 W Lexington ST. 70 WARD)

2-FULL NAME Jacob Tiemann Jr.

(a) RESIDENCE. NO. 1944 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah E. Tiemann

6 DATE OF BIRTH (month, day, and year) Sept 27 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	5	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter. 015
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wheeling W. Va

PARENTS
10 NAME OF FATHER Jacob Tiemann
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md
12 MAIDEN NAME OF MOTHER Emily F Mayberry
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Emory F. Tiemann
(Address) 1944 W Lexington St

15 MAR 10 1921 BOGERT & FRAUNDE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1921, to Mar 8, 1921,
that I last saw him alive on Mar 8, 1921,
and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(duration) 51 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 51 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of
Was there an autopsy? ✓
What test confirmed diagnosis? Clinical

(Signed) E Keller Hemming M. D.
3/9, 1921 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loard = Pa	Mar 10 1921
20 UNDERTAKER	ADDRESS
F B Kuhnert	2236 Frdk

TION is very important. See instructions on back of cer

Spec. 6-9-19—H. P. Co.—1000 Blks.

(over)

D51671

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51671

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 39

CITY OF BALTIMORE: (No 1910 Hilkens Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard G Thomas

(a) RESIDENCE. NO. 1910 Hilkens Ave ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Thomas

6 DATE OF BIRTH (month, day, and year) Oct 26 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Polisher 886

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ralls Md

PARENTS

10 NAME OF FATHER Julius Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Johanna Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mamie Thomas
(Address) 1910 Hilkens Ave

15 FILED MAR 10 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1921

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1921, to March 7, 1921, that I last saw h-- alive on March 6, 1921, and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Larynx.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Intoxication

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward H Mendelsohn M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar. 10 1921
20 UNDERTAKER	ADDRESS
Geo. L. Schwab & Bro	2017 N Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease TION is very important. See instructions on back of certificates.

D-51672

HEALTH DEPARTMENT—CITY OF BALTIMORE.

(Stock)

CERTIFICATE OF DEATH. D-51672

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Stadtlander alias Stern Unknown

(Residence in Baltimore: No. 643 N. Eutaw St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	white	?

6-DATE OF BIRTH, not known, 1860
(Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer): ?

9-BIRTHPLACE, (State or Country), Bavaria

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country) Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mercy Hospital

(Address) Board

15- MAR 10 1921 Filed, 191. [illegible] Register

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mch. 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Mch 7, 1921 (Address) 105 E. Bruce

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery DATE OF BURIAL, 3-10, 1921

20-UNDERTAKER Howard Sandheimer ADDRESS 18 N. Howard

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51673

CERTIFICATE OF DEATH.

REGISTERED NO. 1279

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2432 N. Charles St. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward P. McDevitt

(a) RESIDENCE. No. 2432 N. Charles St. ST., WARD.

(Usual place of abode) Lifetime, (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah M. McDevitt

6 DATE OF BIRTH (month, day, and year) Oct. 12-1854.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physican. 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward McDevitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Sarah McDevitt (Address) 2432 N. Charles St.

15 Filed MAR 10 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March. 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5 1921, to March 8 1921, that I last saw h in alive on March 8 1921, and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia from renal insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Total suppression of urine

(Signed) Chas O'Donovan, M. D.

(Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL 3/11 1921

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51674 HEALTH DEPARTMENT—CITY OF BALTIMORE D51674

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 W. Pratt St. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Fischer

(a) RESIDENCE. No. 1900 W. Pratt ST., 20 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo Fischer

6 DATE OF BIRTH (month, day, and year): Mar 30, 1843

7 AGE: Years 77 | Months 11 | Days 8 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joseph Beall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine Contel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: George Fischer

(Address) 1900 W. Pratt St

15 Filed MAR 10 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8 1921

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to March 9, 1921, that I last saw her alive on March 9, 1921, and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. O'Neill M. D.

3/9, 1921 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Mar 11 1921

20 UNDERTAKER: Geo. Schwab & Bro 101 Eutaw ave — ADDRESS

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D51675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51675

CERTIFICATE OF DEATH.

10-041

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 125 E Gittings ST.: 24 WARD)

2-FULL NAME Sadie Amelia Lusby

(a) RESIDENCE. NO. 125 E Gittings ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson E Lusby

6 DATE OF BIRTH (month, day, and year) May 30 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Solomons Island Md

PARENTS

10 NAME OF FATHER Albert C Tarleton

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Elliott

13 BIRTHPLACE OF MOTHER (city or town) Deals Island (State or country) Md

14 Informant Mrs Nelson E Lusby (Address) 125 E Gittings St

15 Filed MAR 10 1921 ROBERT J. BRAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1921, to March 9, 1921, that I last saw h alive on March 9, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia.

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Lagrippe (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Osborne, M. D.

, 19 (Address) 125 E Gittings

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Solomons Island Md.	June 19
20 UNDERTAKER John F Denny	ADDRESS 713 Eutaw

CAUSES OF DEATH. Please read carefully the inside of back of certificates. See instructions on back of certificates. TION is very important.

25167 HEALTH DEPARTMENT—CITY OF BALTIMORE 25167

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 1845 Lohoman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie V. Morrison

(Residence in Baltimore: No. 1845 Lohoman St. St.: (yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Color	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7-AGE.	If LESS than 1 day,
54 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Jenny

(Address) 1317 Presstman

15-
Filed ..... 191.....
Burial Permit Registered

CAUSE OF DEATH in plain terms, and important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Coronary Thrombosis
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
(Coroner.)
..... 191.. (Address) .....

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Mar 10, 1921

20-UNDERTAKER Edward Ringgold ADDRESS 1463 Carey

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51677

CERTIFICATE OF DEATH

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 639 W Barre St. ST. 72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hatlauer.

(a) RESIDENCE. No. 639 W Barre St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 17. 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit dealer.

(b) General nature of industry, business, or establishment in which employed (or employer) Stall in O'L market.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Eliz Steigler.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Anna Stevens (Address) 639 W. Barre St.

15 Filed MAR 10 1921 [illegible] KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby. 25 1921, to March 9 1921, that I last saw him alive on March. 7 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cedar ½ -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? NO Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) M C Smilinger M. D.

3/9 1921 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	March 11th 1921
20 UNDERTAKER	ADDRESS
Philip Seewald & Son	1825 N. Monroe Ave

TION is very important. See instructions on back of certificate.

Stat.—6-9-19—H. P. Co.—1000 Bks.

D51678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51678

CERTIFICATE OF DEATH.

055-001

1-PLACE OF DEATH Church Home & Infirmary.

CITY OF BALTIMORE: (No. 26 Broadway. ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Albert Langville

(a) RESIDENCE. No. 1604 Jackson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 9 mos. 15 ds. How long in U. S., If of foreign birth? 21 yrs. 9 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~May 24 1899~~

6 DATE OF BIRTH (month, day, and year) May 24-1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grain testers

(b) General nature of industry, business, or establishment in which employed (or employer) Government.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George W. Langville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Hattie Burgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. G. W. Langville (Address) 1604 Jackson

15 FILED MAR 10 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5 1921, to March 9 1921, that I last saw h[illegible] alive on March 9 1921, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) — yrs. — mos. 28 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Physical & Laboratory Tests

(Signed) Richard G. Cottell, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem — DATE OF BURIAL: 3/12 1921

20 UNDERTAKER: S. Frew McCully — ADDRESS: 130 E. Fort

TION is very important. See instructions on back of certificates.

Rev.—6-9-19—H. P. Co.—1000 Bks.

951679 HEALTH DEPARTMENT—CITY OF BALTIMORE 951679

CERTIFICATE OF DEATH.

REGISTERED NO. 579

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 N. Central av ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Brown

(a) RESIDENCE. NO. 529 N. Central av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Brown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Sol Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harris Brown

(Address) 1632 E. Monument St

15 Filed MAR 10 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1921, to March 8, 1921, that I last saw him alive on March 8, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

3-9, 1921 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	3/11/21

20 UNDERTAKER Thos White ADDRESS 1131 Wolfe

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51680

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51680

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 614 N. Cross ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena M. Schaefer

(a) RESIDENCE. NO. 614 N. Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 9 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 19 hrs. or ..... min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Helen E. Kochenderfer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant William Schaefer
(Address) 614 N. Cross St.

15 Filed MAR 10 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1921, to March 10, 1921, that I last saw her alive on March 9, 1921, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Immature birth

5 month

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

(Address) 835 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Mar 10 1921
20 UNDERTAKER	ADDRESS
Jno + Wm John H. Lenfelt & Son	801 W Fayette

mation should be carefully supplied. Age should be stated in years, months and days if it may be properly classified. Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51681

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51681

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St.. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Johnson

(a) RESIDENCE. NO. 902 McCulloh st. ST.. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer's helper

(b) General nature of industry, business, or establishment in which employed (or employer) 611

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Ada Siveling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address) M. T. H.

15 MAR 10 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1921, to March 6, 1921.

that I last saw him alive on March 6, 1921.

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum.

(Signed) L. Rogers, M. D.

3-7-21. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL MAR 10 1921

ADDRESS

20 UNDERTAKER

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

70

Spec. 6-9-19—H. P. Co.—1000 Bks.

D51682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51682

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 76 92 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Harvey

(a) RESIDENCE. No. 3827 E. Lombard St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, ~~Widowed or divorced~~ BUSBAND of ~~Husband~~ (or) WIFE of Widow Hattie V. Harvey

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER William Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Martha Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Hospital Records,

(Address) New City Hospital.

15 Filed MAR 19 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1921, to March 9, 1921, that I last saw him alive on March 9, 1921, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3827 E. Lombard St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Jack R. Morgan. M. D.

(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abeline Va	Mar. 1921
20 UNDERTAKER J Herring & Co	ADDRESS 2005 Eden

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-51683 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1520 850 1370

CERTIFICATE OF DEATH. D-51683 REGISTERED NO. 1870

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 Karamaugh ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Redden

(a) RESIDENCE. No. 1833 Karamaugh ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870 April

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	April 1 mo		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Peter Redden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Addie Washington (Address) 1833 Karamaugh St

15 Filed MAR 10 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to March 1, 1921, that I last saw her alive on March 8, 1921, and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Eczema (duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albumin & Casts

(Signed) Charles L. Clark, M. D.

Mch 9 1921 (Address) 1306 W. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 11 1921
20 UNDERTAKER	ADDRESS
Harwood & Wright	1341 Cary

CAUSE OF DEATH must be stated on back of certificates. ATTENTION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

Liebinnie Carter

D51684 HEALTH DEPARTMENT—CITY OF BALTIMORE D51684

CERTIFICATE OF DEATH.

REGISTERED No. C 16 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 N. Parish ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Liebinnie Carter

(Residence in Baltimore: No. 919 N. Parish St.: 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	single

6-DATE OF BIRTH, Nov (Month) 19 (Day) 1905 (Year)

7-AGE,	If LESS than 1 day,
16 yrs. 3 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Work
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Alabama

PARENTS.

10-NAME OF FATHER, Thomas Carter

11-BIRTHPLACE OF FATHER (State or Country). Alabama

12-MAIDEN NAME OF MOTHER Etta Campbell

13-BIRTHPLACE OF MOTHER (State or Country). Alabama

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Carter

(Address) 919 N. Parish st.

15-

MAR 10 1921 Robert P. Harrison,

Filed ....., 191.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 28 1921, to Mar. 7 1921, that I saw her alive on Mar. 7 1921, and that death occurred, on the date stated above, at 9-20 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — yrs. 0 mos. 8 ds.

CONTRIBUTORY (Secondary) Syph.

(Duration) yrs. mos. ds.

(Signed) Chas. L. McCarthy M. D.

Mar 8, 1921 (Address) 906 N. Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Mar 10, 1921
20-UNDERTAKER	ADDRESS
Brown & Leland	Schroeder

Spec.—8-24-14—M. & T.—2000 Blks.

D51685 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D51685

CERTIFICATE OF DEATH.

REGISTERED NO. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 606 N Vincent St ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Johnson

(Residence in Baltimore: No. 606 N. Vincent St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Dec (Month) Known (Day) 18[illegible] (Year)

7-AGE, 30 yrs. mos. ds.

If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Moving Furn
(b) General nature of industry, business, or establishment in which employed (or employer): Tools

9-BIRTHPLACE, (State or Country), Norfolk Va

PARENTS.

10-NAME OF FATHER, Charles Johnson

11-BIRTHPLACE OF FATHER (State or Country), Norfolk, Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie Johnson

(Address) 606 N. Vincent St.

15- Mar 9, 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-19-21 191, to 3-8-21 191, that I saw h[illegible] alive on 191, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Mucous Colitis, General Debility (Duration) yrs. 1 mos. ds.

(Signed) M. D.

3-9-21, 191... (Address) F. M. Cadazo 524 Pine

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Mar 11, 1921

20-UNDERTAKER Brown & Cleland — ADDRESS 114 N. Schroeder St.

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51686 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51686

CERTIFICATE OF DEATH.

REGISTERED NO. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 Lendenhall ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Lucke

(a) RESIDENCE. No. 1135 Lendenhall ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 6/21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Edgar Lucke

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Irene A. Goetz.

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Edgar K. Lucke
(Address) 1138 Lendenhall st

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1921, to March 8, 1921, that I last saw him alive on March 8, 1921, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Patent Foramen ovale.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy.

(Signed) L. T. Hamman, M. D.

3/9, 1921 (Address) 1 E Read st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Cathedral Cem

DATE OF BURIAL
March 11 1921

20 UNDERTAKER
F. A. Krause & Son

ADDRESS
Lemmon St

AR 101921

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Twin)

D.51687

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51687

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 Leadenhall ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lucke

(a) RESIDENCE. NO. 1135 Leadenhall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Male~~ Female ~~White~~

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 6/21

7 AGE Years Months Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edgar R Lucke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Irene Gerty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Edgar R Lucke

(Address) 1135 Leadenhall St

15 Filed MAR 10 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1921, to Mar 8, 1921, that I last saw h alive on Mar 6, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. S. Hartman M. D.

3/9 1921 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mem Cathedral Cem

DATE OF BURIAL: Mar 11 1921

20 UNDERTAKER: F. C. Graves & Son

ADDRESS: 739 Hanover

R 10 1921

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51688 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51688

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. ST.; 8 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Kornmann

(a) RESIDENCE. NO. 1520 N. Broadway ST., Baltimore
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10th 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Peter Kornmann

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Anna M. Busher

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Louis P. Kornmann
(Address) 1520 N. Broadway

15 Filed APR 4 1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to March 9, 1921, that I last saw her alive on March 9, 1921, and that death occurred, on the date stated above, at 12 M.S.T. m.

The CAUSE OF DEATH* was as follows:

Primary Cancinoma of Gall Bladder
Cholelithiasis.
Emphysema of Gall Bladder
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases to liver.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of Feb 15, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Biopsy

(Signed) R. G. Dorsey, M. D.

, 19 (Address) Home Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 12th 1921
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51689

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51689 ✓

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Darley ave ST.: 8 WARD)

2-FULL NAME George T. Wagenen

(a) RESIDENCE. NO. 1613 Darley ave ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Stella K. Wagenen

6 DATE OF BIRTH (month, day, and year) Mar 29th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George V. Wagenen

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Ida M. Hudgens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mathews Co Va

14 Informant Stella K Wagenen

(Address) 1613 Darley ave

15 Filed MAR 10 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1921, to March 8, 1921, that I last saw him alive on March 8, 1921, and that death occurred, on the date stated above, at 2.47 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert L. Knapp, M. D.

19 (Address) March 9, 1921 1216 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 11th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Son	1126 E Monument

TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D.51690 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51690

CERTIFICATE OF DEATH. 138

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Md Gen. Hosp ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary A. Reuers, (Reves)

(a) RESIDENCE. NO. 217 Chapel St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., If of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Reves

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Martin Reves
(Address) 217 S Chapel

15 Filed MAR 10 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to March 10, 1921, that I last saw h er alive on March 10, 1921, and that death occurred, on the date stated above, at 11 55 a m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Manifestations

(Signed) R. H. Richardson, M. D.

4/10, 1921 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	March 12 1921

20 UNDERTAKER William Galloway Kirk ADDRESS Sandtown

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51691

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. 90 ST., 9 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katie Hartman.

(a) RESIDENCE. No. 327 Furrow ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 35 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Hartman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michal Koniczny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Peter Hartman

(Address) 327 S Furrow St

15 Filed MAR 10 1921 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7, 19 21, to March 8, 19 21, that I last saw h.er alive on March 8, 19 21, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia C. Pregnancy (8 mos.)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. McKelvey, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	March 11 1921
20 UNDERTAKER	ADDRESS
William Gierszewski	168 E

CAUSE OF DEATH must be plainly written, and should state the disease directly causing death, or, if from violence, the nature of injury. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 5 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar – Normal delirium

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51692 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51692

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Weis

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edward Weis.

6 DATE OF BIRTH (month, day, and year) ? 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper. old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Weis

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Elizabeth Mealz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Sister Florence, (Address) Little Sisters Poor

15 Robert P. Harrison, Registrar
R 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17 I HEREBY CERTIFY, That I attended deceased from No Record, 19 , to 19 ,
that I last saw h Sr alive on March 6, 1921,
and that death occurred, on the date stated above, at 2. P. m.
The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Marasmus (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Aldrich, M. D.
Mar 9, 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	MAY 11 1921

20 UNDERTAKER H. C. Kuefeld ADDRESS 914 Gramont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

~~146530~~ D.51693

D.51693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

D.51693

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kimble.

(a) RESIDENCE. No. 516 N Dallas St Balto Md WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ~~unknown~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm H. Kimble.

6 DATE OF BIRTH (month, day, and year) Feb 11-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife.

(h) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Robert A. Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Julia Mewo.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) J Hill Reeves

15 Filed AR 10 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9- 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1921, to March 9, 1921, that I last saw her alive on March 9-, 1921, and that death occurred, on the date stated above, at 10 12 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insuf.
Coronary thrombosis
Contributory Cerebral embolism.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Objective findings

(Signed) Edward C. Davidson, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Daniel Herrlay	Mar 12th 1921
20 UNDERTAKER	ADDRESS
Chas G. Bailey	1421 Jefferson st

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51694 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51694

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 E. Lanvale ST.; 17 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William O. Ousler

(Residence in Baltimore: No. 432 E. Lanvale St.: 30 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March 23rd, 1867. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
53 yrs. 11 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Solicitor of
(b) General nature of industry, business, or establishment in which employed (or employer): Advertising

9-BIRTHPLACE, (State or Country), Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER, Charles Ousler

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co. Md.

12-MAIDEN NAME OF MOTHER Mary Holbrook

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johanna M. Ousler

(Address) 432 E. Lanvale St.

15-

Filed ..... 191 . P. Harrison
Registrar.

AR 10 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct-12th 1920, to March 9th 1921, that I saw h. in alive on March 9th 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Progressive Paralysis

(Duration) yrs. 3 mos. ds.

(Signed) David J. Reinhart M. D.

March 9, 1921. (Address) 2508 N. Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cemt. Lanvale M	March 12, 1921

20-UNDERTAKER	ADDRESS
Wm. Lamb & Son	1723 N. Fayette St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51695 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51695

CERTIFICATE OF DEATH. 109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret Wenther

(a) RESIDENCE. No. 114 S Castle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of WIFE of Joseph Wenther

6 DATE OF BIRTH (month, day, and year) July 7 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Welz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph Wenther (Address) 114 S Castle St

Filed 1 0 1927 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1921, to Mch 9, 1921, that I last saw h[illegible] alive on Mch 9, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mch 8-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C Marino M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mch 19 21
20 UNDERTAKER Kendall Duffy & Son	ADDRESS 37 S [illegible]

TION is very important. See instructions on back of certificates.

D. 51696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51696

CERTIFICATE OF DEATH.

175-001

(PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Scott

(Residence in Baltimore: No. 2128 N. Calvert St.; yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Sgle

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 8 yrs. 3 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....—
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland C

PARENTS.

10-NAME OF FATHER, G Scott

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER E. Burgess

13-BIRTHPLACE OF MOTHER (State or Country), Washington DC

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G Scott

(Address) 2128 Calvert

15- Robert P. Harrison,
Burial Permit Clerk. Registrar.
Mch ....., 191.....

AR 1 01921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mch 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) will be held Mch 10-21 thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull
Struck by auto

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Murphy M. D.
(Coroner.)
Mch 10, 1921 (Address) 1037 Key

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death for time ! In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Washington D. C.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Mar. 12 1921
20-UNDERTAKER	ADDRESS
Geo J. Smith	1006 W. Fayette

CAUSE OF DEATH in plain terms, as time is of great importance. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51697 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51697

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 W. Fayette St.; 14 WARD) REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James M. Correll

(Residence in Baltimore: No. 1614 W. Fayette St.; 64 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 9, 1847 (Month) (Day) (Year)

7-AGE, 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Notary Public.
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Abraham Correll

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Ann Shelton

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter W. Correll

(Address) 820 N. Gilmor St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

AR 10192

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 9, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1921, to Mar. 9, 1921, that I saw him alive on Mar. 8, 1921, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Asthma & Bronchitis

(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. A. Dinkins M. D.

Mar 9, 1921 (Address) 14 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Olivet — DATE OF BURIAL, March 11, 1921

20-UNDERTAKER George J. Smith — ADDRESS 1008 Fay St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51698 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51698

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2512 N. Payson ST.; 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma E. Harten.

(Residence in Baltimore: No. 2512 N. Payson St.; ..... yrs., 10 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F.	W.	Single

6-DATE OF BIRTH, April (Month) 20 (Day), 1920 (Year)

7-AGE, ... yrs. 10 mos. 18 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Walter L. Harten

11-BIRTHPLACE OF FATHER (State or Country), Baltomd

12-MAIDEN NAME OF MOTHER, Rose A. Bard.

13-BIRTHPLACE OF MOTHER (State or Country) Baltomd.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter L. Harten

(Address) 2512 N. Payson St.

15-

Filed ..... 192 ..... Robert P. Harrison, 191

Registrar.

MAR 9 1921

Special Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 6th 1921, to Mar. 9th 1921, that I saw her alive on Mar. 9th 1921, and that death occurred, on the date stated above, at 10:35 a.m.

The CAUSE OF DEATH* was as follows: "Cerebral" Broncho-pneumonia

to my knowledge

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Hoffmann M. D.

3-9-, 1921 (Address) 2100 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	March 11, 1921
20-UNDERTAKER	ADDRESS
George J. Smith	1886 W. Fayette St

D. 51699 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST.: 15 WARD) 75-061

REGISTERED NO. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene H. Archehart

(Residence in Baltimore: No. 4012 Park Heights Ave St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, May (Month) 9 (Day), 1869 (Year)

7-AGE, 51 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): at home 037

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, Robert Hance

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER Mary Scott

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Archehart

(Address) 4012 Park Height Ave

15- Robert P. Harrison, Burial Permit Clerk. Registrar.

Filed ....., 191.....

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

EAR 1892

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Skull fracture, Loss of Skull
Concussion of Brain
Auto & Street Car accident

(Duration) ..... yrs. ..... mos. 1/4 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H. Preston M. D.
(Coroner.)

Mar 10, 1921 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1/4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 4012 Park Heights Ave

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Mar 12, 1921

20-UNDERTAKER H. B. Marshall ADDRESS 3339 Reisterstown Rd

Spec.—8-24-14—M. & T.—2000 Bks.

D.51700 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51700

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED NO. C 92

CITY OF BALTIMORE: (No. Hopkins University St.; Homewood 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J. Hittle

(Residence in Baltimore: No. Hopkins University Homewood St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb 10, 1862 (Month) (Day) (Year)

7-AGE, 59 yrs. mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Heiner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Asked Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Asked Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. William H. Hittle

(Address) Hopkins University Homewood

15- MAR 10 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 4 1921, to March 9 1921, that I saw her alive on March 9 1921, and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. B. Noble M. D.

3.14, 1921. (Address) 814 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bells Cemetery DATE OF BURIAL, Mar 11, 1921

20-UNDERTAKER H. S. Marshall ADDRESS 2539 Fall Rd

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51701 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51701

CERTIFICATE OF DEATH. 6-091

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 644 S. Paca ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eloise Mildred Zeans

(a) RESIDENCE. No. 644 S. Paca ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 - 1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburgh - Pa

PARENTS

10 NAME OF FATHER Leo Zeans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Von Monchs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Wm. H. Joyce 543 S. Paca Stret

15 FILED MAR 10 1921, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1921, to March 10, 1921, that I last saw h[illegible] alive on March 9, 1921, and that death occurred, on the date stated above, at 5-55 A. m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

16 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical sign

(Signed) [illegible] M. D.

3/10 1921 (Address) 729 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity.	March 11 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51702 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51702

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Burkhead

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
calc.	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed Robert P. Harrison, Registrar

AR 107921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to March 9, 1921

that I last saw her alive on March 8, 1921

and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical Exam

(Signed) Jack. R. Morgan. M. D.

3/9/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL March 12 1921

20 UNDERTAKER William Cook

ADDRESS 502 E Hall

Gue

back of certificates. See instructions on back TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51703

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 N Bradford St WARD 8)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A Hoffmann

(a) RESIDENCE. No. 1223 N Bradford St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna D Hoffmann

6 DATE OF BIRTH (month, day, and year) Dec 13/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tinner

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Edward Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Beyfell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Johanna D Hoffmann

(Address): 1223 N Bradford St

Filed MAR 10 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 1 1921 to Mch 9 1921, that I last saw h[e] alive on Mch 8 1921, and that death occurred, on the date stated above, at 4.40 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo Forkenbrock M. D.

Mch 9 1921 (Address) Monument Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mch 11 1921
20 UNDERTAKER	ADDRESS
Wm Leak & Co	526 Cathedral

CAUSE OF DEATH to be plainly written, so that it may be understood in plain terms, so that it may be understood in plain terms. See instructions on back of certificates. TION is very important.

D.51704 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51704

CERTIFICATE OF DEATH.

REGISTERED NO. C 15 156

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1717 Baker St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J. Burns

(Residence in Baltimore: No. 1717 Baker St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Single

6-DATE OF BIRTH, November 5, 1866
(Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Hamessmaker (retired)
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), St. Louis, Mo.

PARENTS.

10-NAME OF FATHER, Nicholas Burns

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Curry

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Burns

(Address) 1717 Baker St.

15-

Filed ....., 191.... Registrar.

MAR 10 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to L.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by inhalation of illuminating gas

about 1½ hr. (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

March 10 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, March 11, 1921

20-UNDERTAKER William Cook — ADDRESS 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D51705

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51705

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 W. Henrietta St.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Tayler.

(Residence in Baltimore: No. 202 W. Henrietta St.; 3 yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Dec. 6, 1917
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
3 yrs. 5 mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, William Tayler.

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER Julia Lyons.

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Tayler

(Address) 202 W. Henrietta

15- MAR 11 1921 ROBERT J. BRAUTEN
Filed....., 191.. Burial Permit Clerk
Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 26 1921, to March 8 1921, that I saw her alive on March 2. 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute Catharral Pneumonia,

..... (Duration).....yrs.....mos. 14 ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Henry Hugo Glunz M. D.

March, 1921 (Address) 933 Hanover.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	March 11, 1921
20-UNDERTAKER John H. Toadvine	ADDRESS 143 Mott St

Looper.

D51706

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Looper

(a) RESIDENCE. No. Dalton Ga. ST., WARD. Dalton Ga.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or, WIFE of)

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cotton Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Hancock Co. Ga.

PARENTS

10 NAME OF FATHER John Washington Looper

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Underwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Dr. E. A. Looper

(Address) 111 W. 29 St

15 Filed MAR 11 1921 ERNEST J. KRAUTH Registrar

Buried from Dalton Ga.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to March 11, 1921, that I last saw him alive on March 11, 1921, and that death occurred, on the date stated above, at 2:15 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia.

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination.

(Signed) E. A. Looper, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dalton Georgia	Mch 11 1921
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1900 W. Mortan

CAUSE OF DEATH in plain terms, so that it may be understood by the laymen. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D51707 HEALTH DEPARTMENT—CITY OF BALTIMORE 92 D51707

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 1103 Patterson Park Av St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Thomas

(Residence in Baltimore: No. 1103 Patterson Park av St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Nov 6, 1830
(Month) (Day) (Year)

7-AGE, 90 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Heinrich Tyfenbach

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Schmidt

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A. E. Thomas

(Address) 1103 Patterson Park av

15- Filed MAR 11 1921, 191.....

Burial Permit Issued — Registered

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 5 1921, to Mar 9 1921, that I saw her alive on Mar. 8 1921, and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Right)

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Hoer M. D.

3-10, 1921. (Address) 5600 York Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cem	March 11, 1921

20-UNDERTAKER	ADDRESS
Chas. E. Franck	801 Madison

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

Zsarkov

D51708 HEALTH DEPARTMENT—CITY OF BALTIMORE 92 D51708

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3175 Nonis ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Zsarkov

(a) RESIDENCE. NO. 317 S Nonis ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) April 27 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Mike Ruczin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Volalya Zsarkov
(Address) 317 S Nonis st

MAR 11 1921 Filed ..... 19 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9/21 19

17 I HEREBY CERTIFY, That I attended deceased from 3/8/21, 19..., to 3/9/21, 19..., that I last saw h alive on 3/9/21, 19..., and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) I H Hamrick M. D.

3/10. 1921 (Address) 1302 N Lombard,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar 12 19 21
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

051709 HEALTH DEPARTMENT—CITY OF BALTIMORE 051709

CERTIFICATE OF DEATH. 151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3175 Mon... ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Zaarkor.

(a) RESIDENCE. NO. 317 E Mon... ST., E WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 7 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Abandon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Elabyos Rangis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Hungary

14 Informant Elabyos Zaarkor
(Address) 317 E Mon... St

15 Filed MAR 11 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/[illegible]8, 19[illegible]4, to 3/[illegible]8, 1921, that I last saw h... alive on 2 m... 19[illegible], and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Premature infant (6 hours.)
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3/9, 1921 (Address) 1302 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 12 1921
20 UNDERTAKER	ADDRESS
John J Fields	1210 W Lombard

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51710

CERTIFICATE OF DEATH.

D51710

REGISTERED NO. 1728

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Sherwood

(a) RESIDENCE. No. 1235 Wilmar Alley ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1803

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Georgia Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed MAR 11 1921 [illegible] Registrar

CAUSE OF DEATH to be stated on back of certificates. ATTENTION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1921

17

I HEREBY CERTIFY, That I attended deceased from February 16 1921, to March 9, 1921, that I last saw her alive on March 9, 1921, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Meningitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 1235 Wilmar Alley

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical Exam

(Signed) Jack R. Morgan, M. D.

3/9/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	March 11 1921
20 UNDERTAKER	ADDRESS
David Earhart	Ca

Spec.—8-24-14—M. & T.—2000 Bks.

D51711 HEALTH DEPARTMENT—CITY OF BALTIMORE D51711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital 26 120 REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... St.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Raymond West

(Residence in Baltimore: No. 3305 O'Donnell St.; 21 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Aug. (Month) 19 (Day), 1892 (Year)

7-AGE.	If LESS than 1 day, ...hrs. or....min.?
28 yrs. 6 mos. 18 ds.	

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shirtcutter
(b) General nature of industry, business, or establishment in which employed (or employer): Do

9-BIRTHPLACE, (State or Country). W. Va.

PARENTS.

10-NAME OF FATHER. Oscar E. West

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Rebecca Dorn

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth West

(Address) 3305 O'Donnell St

15- [redacted] 16. [redacted]

Filed MAR 11 1921 By ..... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 9 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7 1921, to Mar 9 1921, that I saw h[illegible] alive on Mar 1921, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

Mar ? (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) L. Ginsburg M. D.

Mar 9, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn Cemetery

DATE OF BURIAL. March 12, 1921

20-UNDERTAKER H. Sander Sons

ADDRESS 1710 Pierce St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51712 HEALTH DEPARTMENT—CITY OF BALTIMORE D51712

170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4206 Harford Ave ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Frederick

(a) RESIDENCE. No. 4206 Harford ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosina Frederick

6 DATE OF BIRTH (month, day, and year) Aug. 19, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6	19	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Harnessmaker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 3 years ago

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Peter Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherina Reitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna Hehe
(Address) 4206 Harford Ave

15 FILED MAR 11 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1st 1921, to Mar 10, 1921, that I last saw h[illegible] alive on Mar 10, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary Oedema

3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis Valvular Heart Disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) G. L. Mayer M. D.

3/11, 1921 (Address) N 38 E Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	March 12 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Pleasant St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51713 HEALTH DEPARTMENT—CITY OF BALTIMORE D51713

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 527 N. Bond ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa May

(a) RESIDENCE. NO. 527 Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Emmet May

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	36	unknown		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Samuel May
(Address) 1530 N Carey

15 MAR 11 1921 Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1921, to Mch 8, 1921, that I last saw h Sr alive on Mch 7, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis (duration) 1m yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) H. S. McCard M. D.

3/9 1921 (Address) 2008 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Mar 11 1921

20 UNDERTAKER ADDRESS
R & G Frost 1405 McElderry

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51714

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 N Vincent St. 16 WARD)

2-FULL NAME Agnes Mullan

(a) RESIDENCE. NO. 1002 N Vincent St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Andrew Mullan

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Agnes Ball

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14 Informant Agnes Mullan (Address) 1002 Vincent St

15 FILED MAR 11 1921 ROBERT E. LEAUTEY Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to March 8, 1921, that I last saw h.. alive on March 8, 1921, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Thomas Nelson, M. D.

. 19 (Address) 1001 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Mar. 10 1921
20 UNDERTAKER	ADDRESS
James H Dennis	1303 Presstman St

CAUSE OF DEATH in plain terms, so that it may be understood on back of certificates.
TION is very important. See instructions on back.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy." "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec. 6-9-19—H. P. Co.—1000 Blks.

D51716 — D51715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Powell

(a) RESIDENCE. NO. Reisterstown Md ST., ... WARD. Reisterstown Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustavus Powell

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic wife

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Robert Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Gustavus Powell (Address) Reisterstown Md

15 Filed MAR 11 1921 ROBERT J. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1921, to March 9, 1921, that I last saw her alive on March 9, 1921, and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.
& Carcinoma of Breast.

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes. Date of 3/2/21

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) C. Wilbur Stewart. M. D.

3/9, 1921 (Address) Maryland General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Mar 12 1921
20 UNDERTAKER	ADDRESS
J. F. Ebert	Reisterstown Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF BURIAL is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4D51716

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2409 Christian ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arabella Dixon

(a) RESIDENCE. No. 2409 Christian ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single, Married~~, Widowed, or ~~Divorced (write the word)~~: Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel T. Dixon

6 DATE OF BIRTH (month, day, and year): July 4 1857

7 AGE — Years: 63 Months: 8 Days: 5 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Samuel Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Eckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Viola D. Schlein (Address) Lansdowne

15 Filed MAR 11 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 9 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920, to Mch 9 -, 1921, that I last saw her alive on Mch. 9 -, 1921, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Carcinoma of Liver & Stomach. (duration) About 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W Burns Woodward, M. D.

Mch 10, 1921 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	March 12 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2178 Pa.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NAME OF DISEASE is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D51717 HEALTH DEPARTMENT—CITY OF BALTIMORE D51717

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 949 Franklin road St.; 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Buckner

(Residence in Baltimore: No. 949 Franklin road St.; 46 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, unknown (Month), (Day), 1872 (Year)

7-AGE, 49 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) London Co Va

PARENTS.

10-NAME OF FATHER, Peter Buckner

11-BIRTHPLACE OF FATHER (State or Country) London Co Va

12-MAIDEN NAME OF MOTHER Eliza Carey

13-BIRTHPLACE OF MOTHER (State or Country) London Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H Buckner

(Address) 949 Franklin road

15- MAR 1 1921 ROBERT I. KRAUTH

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 7th 1921, to Mch 8 1921, that I saw him alive on March 7th 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

1 week (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Heart Failure (Duration).....yrs.....mos.....ds.

(Signed) John L Manger M. D.

....., 191... (Address) 1002 Edmondson Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Calvary Frankfurt Road

DATE OF BURIAL, 3/11....., 1921

20-UNDERTAKER Samuel T Kemsley

ADDRESS 978 N Eutaw

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51718

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1045 Chapel ST.: 23 WARD)

2-FULL NAME Robt F Schmidt

(a) RESIDENCE. No. 1045 Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William C. Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Edith Otto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant William C. Schmidt
(Address) 1045 N. Chapel St.

15 Filed MAR 11 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10 — 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28 1921 to Mar 10 1921, that I last saw him alive on Mar 10 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Congenital Convulsions

(duration) — yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A Krauskopf M. D.

, 19 (Address) 1340 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Mar 11 1921

20 UNDERTAKER J Schumann & Son ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Form laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause Unknown

Spec.—8-24-14—M. & T.—2000 Bks.

D 51719

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 301 Club Road St.; 29th WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura King Jones

(Residence in Baltimore: No. 301 Club Road St.; life yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec (Month) 15 (Day), 1845 (Year)

7-AGE, 75 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John King

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Caroline Griffith

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George L Bagby

(Address) 301 Club Road

15-
Filed MAR 11 1921, 191.....
ROBERT F. KRAUTER
Registrar.

Burial Permit Issued

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 21 1920, to March 9 1921, that I saw her alive on March 9 1921, and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Left Cerebral Hemiplegia due to
Cerebral Hemorrhage resulting from
Arterio-Sclerosis

(Duration) 1 yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Pulmonary Infarctions

(Duration) 1 yrs. mos. 9 ds.

(Signed) M. Gibson Petty M. D.

Mar. 11, 1921. (Address) 422 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, March 11, 1921

20-UNDERTAKER John O. Mitchell — ADDRESS 1701 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51720

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51720

CERTIFICATE OF DEATH.

91-690

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 Wesley Av. ST.; 17 WARD)

2-FULL NAME Eliza Barnes

(a) RESIDENCE. No. 426 Wesley Av ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	~~Single~~ Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Single~~ Widow

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	—	—	—	

8 OCCUPATION OF DEECEASED Laundress #1

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Laundrese

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Co

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Martha Cay
(Address) 429 St Mary's St

15 Filed MAR 11 1921 ROBERT A KRAUTER Registrar
Burial Permit 61608

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5th, 1921, to March 9th, 1921, that I last saw her alive on March 8th, 1921, and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH* was as follows:

Bronchitis and
Bronchi pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Ud Date of Ud

Was there an autopsy? Ud

What test confirmed diagnosis? Physical Diag.

(Signed) Ged Hall, M. D.

, 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	March 11 1921
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	1725 Ashland Av

CAUSE OF DEATH in plain terms, without abbreviations. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1900 Bks.

D51721

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51721

CERTIFICATE OF DEATH.

1040

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 N. Lexington St. ST.; 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard N. P. Decker

(a) RESIDENCE. NO. 900 N. Lexington St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard N. Decker

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Leonard F. Decker

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Ida F. Nicholas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Leonard F. Decker
(Address) 900 W. Lexington Street

15 Filed MAR 11 1921 ROBERT I. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 10, 1921, that I last saw h.im alive on March 10, 1921, and that death occurred, on the date stated above, at 11. A. m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(duration) ....yrs. ....mos. 4 hours.

CONTRIBUTORY (Secondary) Indigestion

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray, M. D.

, 19 (Address) 510. N. Fremont ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	3-11-1921
20 UNDERTAKER H. C. Williams & Co.	ADDRESS 617 N. Eutaw St

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enterostomie

Spec.—8-24-14—M. & T.—2000 Bks.

951722 HEALTH DEPARTMENT—CITY OF BALTIMORE 951722

CERTIFICATE OF DEATH.

REGISTERED No. C 6742

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 N. Stricker ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Jones

(Residence in Baltimore: No. 1105 N. Stricker St.; 30 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. August (Month) 24 (Day), 1844 (Year)

7-AGE. 76 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Talbot Co Md

PARENTS.

10-NAME OF FATHER. Wm Starkey

11-BIRTHPLACE OF FATHER (State or Country). Talbot Co Md

12-MAIDEN NAME OF MOTHER Ellen Baker

13-BIRTHPLACE OF MOTHER (State or Country). Talbot Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F. Jones

(Address) 1105 N Stricker St

15- Filed MAR 1 1921, 191.... Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 2 1921, to Mar. 10 1921, that I saw h[er] alive on Mar. 10 1921, and that death occurred, on the date stated above, at 2-10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. McCarthy M. D.

Mar 10, 1921 (Address) 906 N. Stricker St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Western — DATE OF BURIAL. Mar 14 1921

20-UNDERTAKER Geo W Little — ADDRESS 531 N Fremont Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51723

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51723

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 So Smallwood Ave WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Glatthaar

(a) RESIDENCE. NO. 300 So Smallwood ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hair Spinner Spinner 1886

(b) General nature of industry, business, or establishment in which employed (or employer) Hair Factory

(c) Name of employer Wilkins

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown McG.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John Bauer 3005 Smallwood

15 MAR 11 1921 [illegible] Registrar

Registrar of Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17

I HEREBY CERTIFY, That I attended deceased from During 1919 to past 2 years 1919, that I last saw him alive on March 9, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Int Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Fred Koldenn M.D.

1921 (Address) 84 So Dualon Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery MR. & MRS. N. S. FINK.	MAR 11 1921
20 UNDERTAKER FUNERAL DIRECTORS 1835 W. PRATT STREET.	ADDRESS Western Cemetery

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51724

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 W. North Ave. St.; 15 Ward) 170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Stern

(a) RESIDENCE. No. 2226 W North Av St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Meier Stern

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Chas Stern
(Address) 2226 W North Ave

15 Filed , 19 ROBT. J. LANTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 , 1920 , to March 10 , 1921 , that I last saw her alive on March 9th , 1921 , and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. 1 ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. & Exam. of Urine

(Signed) Geo. W. Billups , M. D.

, 19 (Address) 222 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clark Shalom	3/13 1921
20 UNDERTAKER	ADDRESS
Wm H Sondheim	1108 Arlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D51725 HEALTH DEPARTMENT—CITY OF BALTIMORE 91 D51725

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #643 W. Franklin Street ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Schleunes

(Residence in Baltimore: No. #643 W. Franklin Street St.; 70 yrs., ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widowed

6-DATE OF BIRTH, November (Month) 24 (Day), 1833 (Year)

7-AGE, 87 yrs. 3 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Cloth
(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, George Schleunes

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Stoll

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Francis Schleunes Jr(son)

(Address) #643 W. Franklin Street

15- Filed MAR 11 1921 191.....

ROBERT F. BRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 5th 191.., to March 10 1921, that I saw h im alive on March 9 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Joseph E. Gidmann M. D.

March 16 1921. (Address) 1316 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Mar-12-21, 191...

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH must be stated plainly and accurately. Important. See instructions on back of certificate.

Spec.—6-24-14—M. & T.—2000 Bks.

D51726

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51726

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital. ST.; 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Meyers.

(Residence in Baltimore: No. 6209 York Road St.; 0 yrs., 0 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	White	Baby.

6-DATE OF BIRTH, Feb (Month) 23 (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
0 yrs. 0 mos. 14 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, Eugene Rogus Meyers.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore.

12-MAIDEN NAME OF MOTHER Jessie Merryman.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E A Duncan

(Address) Woman's Hospital

15-

Filed....., 191.... ROBERT J. KRAUTER Registrar.

MAR 11 1921 Burial Permit Issued

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 6 1921, to March 10 1921, that I saw h er alive on March 10 9 PM 1921, and that death occurred, on the date stated above, at 9:10 P m.

The CAUSE OF DEATH* was as follows:

Septicemia - (Staphlococcus)

(Duration) ....yrs....mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ....yrs....mos. 2 ds.

(Signed) Frank Worth - for M. D.

March 10, 1921. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 5 ds. In the State....yrs....mos. 14 ds.

Where was disease contracted, if not at place of death? 6209 York Road.

Former or usual residence 6209 York Road

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery DATE OF BURIAL, March 11, 1921

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 106 W. NORTH AVE.

Form —6-9-19—H. P. Co.—1000 Bks.

D51727 HEALTH DEPARTMENT—CITY OF BALTIMORE D51727

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. George Hotel ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Eugene Reindollar

(a) RESIDENCE. No. St. George Hotel ST., 11 WARD. (Taneytown, Md)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? 68 yrs. 0 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida K. Reindollar.

6 DATE OF BIRTH (month, day, and year) Feb-18-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grain Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Grain

(c) Name of employer (Self)

9 BIRTHPLACE (city or town) (State or country) Taneytown, Carroll Co Maryland

PARENTS

10 NAME OF FATHER David Reindollar

11 BIRTHPLACE OF FATHER (city or town) Taneytown (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Hichew

13 BIRTHPLACE OF MOTHER (city or town) Taneytown (State or country) Maryland

14 Informant Mr. E. E. Reindollar, (son)
(Address) 2-Englewood Road, Roland Park

15 Filed MAR 11 1921 ROBERT I. KLAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1921, to March 10, 1921, that I last saw him alive on March 10, 1921, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chronic Myocarditis & Angina Pectoris. (duration) years. yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. T. Shaw, M. D.

3/10/1921 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Taneytown, Carroll Co. Md.	Mar-11-21

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

051728

HEALTH DEPARTMENT—CITY OF BALTIMORE

051728

CERTIFICATE OF DEATH.

55-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1042 W Fayette St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madelaine A Ettinghead

(Residence in Baltimore: No. 1042 W Fayette St.; 64 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Dec 23, 1856 (Month) (Day) (Year)

7-AGE, 64 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John N McCoy.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Madeleine Hanson

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Mastone

(Address) 1042 W Fayette

15- MAR 11 1921 ROBERT F KRAUTER

Filed ....., 191 Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 14 1921, to March 9 1921, that I saw h er alive on March 9 1921, and that death occurred, on the date stated above, at 1.50 P m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(Duration) .....yrs. .....mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(Duration) .....yrs. .....mos. 2½ ds.

(Signed) Dan. Mechlinson M. D.

March 10, 1921 (Address) 1420 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL, March 13, 1921

20-UNDERTAKER Cook & Jones — ADDRESS 1424 N Broadway

According to law, the person who signs this certificate is required to answer carefully and truthfully all questions on it, as far as practicable, and to add any important information concerning the case which may be known to him. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51729

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Miller

(a) RESIDENCE. NO. 622 N Pledmont St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 2 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Abe Miller

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Rosie Kaplin

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Hospital Record
(Address) J. H. H.

15 Filed MAR 11 1921 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10 1921, to March 11 1921, that I last saw h[illegible] alive on March 11 1921, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Empyema (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Thoracentesis

(Signed) Horton Casparis, M. D.

3-11, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: Mar 11 21

20 UNDERTAKER: M Levinson — ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Any physician willfully making a false certificate is guilty of a misdemeanor. Any undertaker willfully failing to file a certificate as required by law

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51730 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51730

CERTIFICATE OF DEATH.

143

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hospital (St.) 27 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius F. Wegner

(a) RESIDENCE. (No.) 4755 Park Heights ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Wegner

6 DATE OF BIRTH (month, day, and year) Nov 26, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant Keeper

(b) General natore of industry, business, or establishment in which employed (or employer) 043

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Julius Wegner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ? Eisenhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Fannie Wegner (Address) 4755 Park Hts Ave

15 Filed MAR 11 1921 ROBERT J. KRAUTH Registrar Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1921, to Nov 9, 1921, that I last saw h.m alive on Nov 9, 1921, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Carbuncle of upper lip

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Streptococcic Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Nov 8, 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lyman J. Abbott, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Mar 12 1921

20 UNDERTAKER Wm J Tickner & Son ADDRESS N & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51731 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51731

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 27 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Dream.

(a) RESIDENCE. No. 3 Brackett ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jun 17 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55.	1	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse. 048

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Richard Dream

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann R Berthy

13 BIRTHPLACE OF MOTHER (city or town) Ireland.
(State or country)

14 Informant Mrs J L Rebbel.
(Address) 3 Brackett ave

Filed MAR 11 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9 — 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1921, to Mar. 9, 1921, that I last saw her alive on Mar. 9, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall ducts

Indigent.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 2, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. McElwain, M. D.

, 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Mar 12 1921

20 UNDERTAKER E O Fanning ADDRESS Lafayette

Dec 1938 L

GIVE should be stated EXACTLY. The name of the mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

(Maychozak)

D.51732 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51732

CERTIFICATE OF DEATH. 167

1-PLACE OF DEATH REGISTERED No. C.....

CITY OF BALTIMORE (No. Hopkins Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kazmiera michael

(Residence in Baltimore: No. (Glenburney) St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Baby

6-DATE OF BIRTH, May 8, 1916 (Month) (Day) (Year)

7-AGE, 4 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 600

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Feliks Mychozak

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Leokadia Niewiadomska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Feliks Mychozak

(Address) Glen Burnie Md.

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MAR 1 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. Clothes caught fire from stove

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm H. Fraley M. D. (Coroner.)

5-11-, 192.., (Address) 120 E. East

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Glen Burnie Md.

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, March 12 1921

20-UNDERTAKER John A Weber — ADDRESS 1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51733 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51733

CERTIFICATE OF DEATH. 91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 Freida Ave. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis E. Kostens

(a) RESIDENCE. No. 202 Freida Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10th 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. yo

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Kostens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Catherine A. Hurzbaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant William Kostens

(Address) 202 Freida Ave.

15 Filed Robert P. Harrison, Registrar

MAR 11 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11th 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 8 , 1921 , to Mar 11 , 1921 , that I last saw him alive on Mar 10 , 1921 , and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) A. Lee Hebard M. D.

(Address) Maplewood & Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cemetery	March 14th 1921
20 UNDERTAKER	ADDRESS
Mr. & Mrs. John H. Teufel.	801 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be stated mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51734 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51734

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 N. Fremont ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Wagner

(a) RESIDENCE. No. 21 N. Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henrietta Wagner

6 DATE OF BIRTH (month, day, and year): apr. 6, 1829

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter 50

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant (Address): Charles E. Wagner 21 N. Fremont St.

15 Filed MAR 11 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 10 1921.

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to March 10, 1921.

that I last saw he[illegible] alive on Mar 7, 1921.

and that death occurred, on the date stated above, at 11.55 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: Mar. 12 1921

20 UNDERTAKER: Jno. Wm. Teufel & Son

ADDRESS: 801 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~6945~~ D. 51735 — D. 51735

CERTIFICATE OF DEATH.

X 79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospt ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Smith

(a) RESIDENCE. No. 1011 Druid Hill Ave ST., WARD.
(Usual place of abode) Baltimore
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Smith

6 DATE OF BIRTH (month, day, and year): Jan 7. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Virginia

PARENTS

10 NAME OF FATHER: Tenora Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): West. Virginia

12 MAIDEN NAME OF MOTHER: Celia Bryans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant (Address): J. H. Hospital Records

15 Filed: Mar 11 1921 — Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1921, to March 11, 1921, that I last saw h[illegible] alive on March 11, 1921, and that death occurred, on the date stated above, at 6 20 a m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertension, arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? B.P. urine findings Clinical picture

(Signed) Edward C. Davidson, M. D.

3-11, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charleston W. Va.	Mar. 11 1921
20 UNDERTAKER	ADDRESS
Jas B Cook.	1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 1 1 1921

D-51736

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-51736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 N. Payson ST.; 16 WARD)

2-FULL NAME Sadie Mentz

(a) RESIDENCE. NO. 1004 N. Payson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Mentz

6 DATE OF BIRTH (month, day, and year) Feb 12 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Albers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sadie Albers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred Weisenborn
(Address) 1004 N Payson St

15 Filed MAR 1 1921 Robert F. Harrison Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to March 10, 1921, that I last saw her alive on March 4, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Gall Bladder
Exhaustion 4 weeks prior
2 months

(duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Cancer of Liver

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	3/13 1921

20 UNDERTAKER J Ahrens & Co ADDRESS 15 W Mos[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-51737

D-51737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1915 W. Lanvale ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Glaser

(a) RESIDENCE. No 1915 W. Lanvale St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis Glaser dont know

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Moses Lowenthal

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Joseph Glaser
(Address) 1915 W. Lanvale St

15 Filed MAR 11 1921 19.....

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 16th, 1920, to March 8th, 1921, that I last saw h alive on March 8th 1921, and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis
Mitral Regurgitation
Ch. Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. W. Cleary M. D.

(Address) 405 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	3/13 '21
20 UNDERTAKER	ADDRESS
J. Ahern & Co	1611 Mad. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact address of decedent TION is very important. See instructions on back of certificates.

D. 51738 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51738

CERTIFICATE OF DEATH. 184

1-PLACE OF DEATH Lunch Room REGISTERED NO. C.....

CITY OF BALTIMORE (No. ~~1020 McCauley~~ ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Stelka

(Residence in Baltimore: No. 1020 McCauley St.: yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, November 1 1905
(Month) (Day) (Year)

7-AGE, 46 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home 037
(b) General nature of industry, business, or establishment in which employed (or employer): work

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Thomas Drab

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Stelka

(Address) 1020 McCauley

15-

Filed MAR 11 1921, 191.....

Robert P. Harrison, Registrar.
~~Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Self Induced

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. T. Bayley M. D.
(Coroner)

3-10, 1921 (Address) 706 E. Lex.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Hill	March 12, 1921
20-UNDERTAKER	ADDRESS
Frank Brach Son	1906 Boston

R. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

D.51739 HEALTH DEPARTMENT CITY OF BALTIMORE D.51739

(Yiraky)

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 606 n ST.: Streeper st. WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Yirak.

(Residence in Baltimore: No. 606 n Streeper st, St.; yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March, 1 ..... (Month) (Day) (Year)

7-AGE, 36 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ship Yard

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Wm Brown

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Ann Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Yirak

(Address) 606 n Streeper st

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MAR 11 1921

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Mills M. D. (Coroner.)

....., 191... (Address) 606 E. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, March 14 1921.

20-UNDERTAKER Frank E. Enoch & Son

ADDRESS 1906 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51740

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lewis

(a) RESIDENCE. NO. 735 Sterling st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Lewis Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Cora Annison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Address) Hospital Records M.T.H.

15 Filed Robert P. Harrison, Registrar

MAR 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1921

17 I HEREBY CERTIFY, That I attended deceased from January 21, 1921, to March 3, 1921, that I last saw her alive on March 2, 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum; X-ray

(Signed) L. S. Fahnestock, M. D.

3-3-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

Commissioner Health.

MAR 11 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

Dl. 51741

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dl. 51741

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 519 Burgundy ST.: W WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Young.
(Residence in Baltimore: No. 519 Burgundy ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... Don't Know (Month) (Day) (Year)

7-AGE. 38 about yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Don't Know

11-BIRTHPLACE OF FATHER (State or Country). " " "

12-MAIDEN NAME OF MOTHER " " "

13-BIRTHPLACE OF MOTHER (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Robert P. Harrison,
Filed ....., 191.... Registrar.

MAR 11 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. Don't Know mos. ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... W. K. Gorsuch M. D.
(Coroner.)

3-8, 1921. (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, ... DATE OF BURIAL, ..., 19....

20-UNDERTAKER ..... ADDRESS .....

MAR 11 1921

Dr. Wm. R. WOODALL
Commissioner Health

Please write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51742

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51742

X 64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1332 Hollins ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A Cole

(a) RESIDENCE. NO. 1332 Hollins St ST., WARD. Phila. Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas Tolan

6 DATE OF BIRTH (month, day, and year) Feb 10 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER Wm Toland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Sarah A Toland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Amanda Buxton

(Address) 1332 Hollins St

15 Filed MAR 11 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 8th, 1921, to March 11th, 1921, that I last saw her alive on March 11th, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia. Apoplexy. ow

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Pulmonary Tuberculosis Jan 27 '21

yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Henry D Koll, M. D.

, 19 (Address) 1203 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Mar 12 1921
20 UNDERTAKER Robert Brockerson	ADDRESS Gilmore Hollins

MAR 11 1921

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS mation may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51743 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51743

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tom Smithers

(a) RESIDENCE. No. 225 S. Bond st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mae Smithers

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hat cleaner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Simon Smithers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Records
(Address) M.T.H.

15 Filed 19 Robert P. Harrison, Registrar

MAR 11 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1920, to March 9, 1921, that I last saw him alive on March 9, 1921, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. Hajny, M. D.

3-9-21. 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Mar 12 1921

20 UNDERTAKER Robert Brokerson

Brokerson Hoddens

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51744 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 18 WARD) 79

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Hilda Corder

(a) RESIDENCE. No. 1135 W. Lombard St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46				

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Miss Hilda Corder.
(Address) 1135 W. Lombard St

15 Filed Robert P. Harrison, Registrar

R 1 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-11 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-6, 1921, to 3-11, 1921, that I last saw h[illegible] alive on 3-11, 1921, and that death occurred, on the date stated above, at 3 55 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. McCraig M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	Mar 14 1921
20 UNDERTAKER J. Carl Brockerm	ADDRESS Baltimore Holliday sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE, INJURY, or MEANS OF VIOLENCE is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

46650
D. 51745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51745

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.) 29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph J Lowdenslager Jr

(a) RESIDENCE. No. 7 Lewiston Ave Arlington ST., Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	2	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ralph Lowdenslager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Zilt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant ..... (Address) Johns Hopkins Hospital Records

15 Filed MAR 11 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1921, to March 10, 1921, that I last saw h alive on March 10, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James C. Fox Jr, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Mar 14 1921
20 UNDERTAKER	ADDRESS
W M Rowlson	230 N Greene

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.51746 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51746

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 N Gilmor St. 16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Organer

(a) RESIDENCE. No. 1138 N Gilmor St., Ward. Walkersville Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Organer

6 DATE OF BIRTH (month, day, and year) April 21, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Farming.

(c) Name of employer Ind & Co. Ind.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Cramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Buckey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Walter B Stevens

(Address) 1138 N Gilmore

15 Filed 19 Robert P. Harrison Registrar

APR 1 1921 Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1921, to March 9, 1921, that I last saw him alive on March, 1921, and that death occurred, on the date stated above, at 5 A.M. The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Shawhan, M. D.

3/9, 1921 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Walkersville Md.	Mar 12 1921
20 UNDERTAKER	ADDRESS
H M Routson	230 N Gmore

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT SPECIFICATION OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51747

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51747

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3213 Baker St ST.: 16 WARD)

2-FULL NAME John S Zile

(a) RESIDENCE NO. 3213 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Zile

6 DATE OF BIRTH (month, day, and year) Aug 27

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER a Zile

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs P Wood (Address) 3213 Baker St

15 Filed Robert P. Harrison, Registrar

MAR 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1927

17 I HEREBY CERTIFY, That I attended deceased from Mch. 1, 1927, to Mch 9, 1927, that I last saw him alive on March 9, 1927, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 2 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H S Goss, M. D.

3/10, 1927 (Address) 6 W 11 Mt Ver Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Mar 12 1927
20 UNDERTAKER	ADDRESS
W M Rowton	230 N Green

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.5-1748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.5-1748

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 N. Washington, WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Forster

(a) RESIDENCE. NO. 1015 N. Washington st., WARD. 7

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Forster

6 DATE OF BIRTH (month, day, and year) Nov 28-1829

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	92	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ax House

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christine McGuigan

(Address) 1015 N. Washington

15 Filed ..., 19... Robert F. HARRISON, Registrar

[Burial Permit Clerk.]

MAR 11 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1921, to Mar. 11, 1921, that I last saw h[illegible] alive on March 9, 1921, and that death occurred, on the date stated above, at 1139 a m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

No Hemorrhage

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bed sore

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

3/11/1921 (Address) 1223 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	3-14 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51749 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51749

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Miller

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 470

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records, New City Hospital
(Address)

15 Filed MAR 11 1921, 19... Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from September 1, 1914 to March 10, 1921 that I last saw her alive on March 10, 1921 and that death occurred, on the date stated above, at 1:15 P.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical test

(Signed) Jack R. Morgan, M. D.

3/10/1921 (Address) City View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 12- 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Leona)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51750 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51750

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 339 Dauphin ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena L. Weingarten

(a) RESIDENCE. No. 339 Dauphin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wht	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 22 / 19

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	One	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Herman Weingarten

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Lillie Frank

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Herman Weingarten
(Address) 339 Dauphin St

15 Filed ..... 19 ..... Registrar

APR 1 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17

I HEREBY CERTIFY, That I attended deceased from Feby 2, 1921, to March 10, 1921, that I last saw her alive on March 10, 1921, and that death occurred, on the date stated above, at 10.05 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis
with Hemiplegia

(duration) yrs. One mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis with Myocarditis Heart Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible Symptoms

(Signed) E. A. Smith, M. D.

, 19 (Address) 605 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	March 12 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. Natt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-closure Foramen
Orale.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Samuel E. Hare

051751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-284 051751

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 Berry St ST. 12 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel E Hare

(a) RESIDENCE. No. 812 Berry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year) Sept 14 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Hare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Hare (Address) 812 Berry st

15 Filed MAR 11 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1st, 19 21, to Mar 10, 19 21, that I last saw him alive on Mar 10 19 21, and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchitis (Pneumonia)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

3/11, 1921 Address) 846 W Hatt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester Md	March 13 1921

20 UNDERTAKER Chenowith Ley ADDRESS Chestnut St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51752 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51752

CERTIFICATE OF DEATH. 92-074

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~Hahnemann~~ Hospital (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Aldred.

(a) RESIDENCE. No. 3411 Hanford St. East WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edith May Aldred.

6 DATE OF BIRTH (month, day, and year) May 15-1880

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) White Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Scotland (State or country)

12 MAIDEN NAME OF MOTHER Scotland

13 BIRTHPLACE OF MOTHER (city or town) Scotland (State or country)

14 Informant Edith M. Aldred (Address) 3411 Hanford Road

15 Filed MAR 11 1921, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/ 1921

17

I HEREBY CERTIFY, That I attended deceased from March 9, 1921, to March 10, 1921, that I last saw him alive on March 10, 1921, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) Yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) Elmer B Hall, M. D.

, 19 (Address) 617 E Northlake

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	March 14 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 51753

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2722 Hampden st. 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B Lowell

(a) RESIDENCE. No. 2722 Hampden st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Lowell

6 DATE OF BIRTH (month, day, and year) Sept 4 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinest

(b) General nature of industry, business, or establishment in which employed (or employer) 31

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) M D

PARENTS

10 NAME OF FATHER John Lowell

11 BIRTHPLACE OF FATHER (city or town) (State or country) M D

12 MAIDEN NAME OF MOTHER Bertie Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) M D

14 Informant Josephine Lowell

(Address) Robert P. Harrison

15 Filed MAR 11 1921, 19.....

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1920, to March 11, 1921, that I last saw h alive on March 10, 1921, and that death occurred, on the date stated above, at 10:15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of colon

(duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of April 20

Was there an autopsy? No

What test confirmed diagnosis? Findings at operation

(Signed) R. L. Norment M. D.

11, 1921 (Address) 314 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	March 14 1921
20 UNDERTAKER	ADDRESS
Chenowett & Son	Chestnut

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 51754 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51754

CERTIFICATE OF DEATH.

159

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Druid Hill Park St.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gluckstein Jr

(Residence in Baltimore: No. 2020 Mt Royal Terrace St.; yrs. 33 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Mar. 25, 1887
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Mfr
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Gluckstein

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Th Gluckstein

(Address) 2020 Mt Royal Terr

15- Filed MAR 11 1921, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 9, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wound
Struck to head
(Duration) yrs. mos. ds.
Suicide
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas Schnorrenberg M. D.
Mar 9, 1921 (Coroner)
(Address) 1432 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, March 12 1921

20-UNDERTAKER Chenoweth & Son — ADDRESS Chestnut Ave

8.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, state number of hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51755 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51755

42

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 E Biddle St. 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella N. Hobble

(Residence in Baltimore: No. 936 E Biddle St. St.; ....yrs. ....mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Feb 12 (Month) (Day), 1859 (Year)

7-AGE, 61 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John H Kelly

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Isabella Deutz

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Biggs

(Address) 936 E Biddle St

15-

Filed ....., 191....

Robert P. Harrison,
Registrar.

Burial Permit Clerk

MAR 11 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/15 1921, to 3-11 1921, that I saw h[er] alive on 3-10 1921, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri

Clinical diagnosis, Metastasis

(Duration) 1 yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Anemia arrhoea

(Duration) 10 yrs. ....mos. ....ds.

(Signed) D. Bernard Wise M. D.

3/11, 1921 (Address) 914 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Pk Grn — DATE OF BURIAL, Mar 14, 1921

20-UNDERTAKER Robt Kinner & Son — ADDRESS 1424 Pine

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51756

D. 6702

+ 42

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Cluter

(a) RESIDENCE. NO. 5 Clinton Terrace ST., WARD. Schenectady N. Y.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24/1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home-work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Cornelius Tuller

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York.

12 MAIDEN NAME OF MOTHER Catherine Finan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York.

14 Informant J. H. Hospital Records
(Address) Miss Margaret Mains

15 Filed 10 Sept. 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10. 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7. 1921, to March 10. 1921, that I last saw h.. alive on March 10. 1921, and that death occurred, on the date stated above, at 6 P— m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of ovary

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 7, 21

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Leo Brady, M. D.

3-11, 19.. (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schenectady N. Y.	March 11 192
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette St

Information should be carefully supplied. ALL items should be filled in, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20.51757 (Breeback) HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1624 Vogts Lane ST.: Gadsden WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C Breeback,

(Residence in Baltimore: No. Vogts Lane ST.: Gadsden yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 28th (Month) (Day), 1880 (Year)

7-AGE, 41 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Ulrich Thim

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER Catherine Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Breeback

(Address) Crutchersville Ind.

15-

Filed MAR 1 1921, 191.... Robert F. Harrison, Registrar.

Burial Permit Issued.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Hunt Jones (Coroner) M. D.

Mar 10 1921 (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cemetery | DATE OF BURIAL, March 12 1921

20-UNDERTAKER Fredk Loeser & Sons | ADDRESS Fulkerson Ind

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—6-9-19—B. P. Co.—1000 Blks.

D-51758

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-51758

CERTIFICATE OF DEATH

91

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... St.: 21 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Doyle

(a) RESIDENCE. No. 1157 Sargent St., Ward.

(Usual place of abode) (if nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) About June 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hospital

15 Filed MAR 11 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1921, to March 11, 1921, that I last saw h.. alive on March 11, 1921, and that death occurred, on the date stated above, at 9.20 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) H. Goldsmith M. D.

3/11/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 14 1921
20 UNDERTAKER William Cook	ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20.51759 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51759

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1600 Eutaw Place ST.: 14 WARD) REGISTERED No. C 92

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie G. Johnston

(Residence in Baltimore: No. 1610 Eutaw Place St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	Widow

6-DATE OF BIRTH, November, 1851.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
70 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): NO

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Wm. Goodhan

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Nelson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Katie M. G. Johnston

(Address) 1600 Eutaw Place

15-

Robert F. Harrison,

Filed ..... 191.....

APR 11 1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Double)
(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) no history
(Duration) yrs. mos. ds.

(Signed) J. E. D. Hennessy M. D.
(Coroner.)

March 11, 1921 (Address) 2802 Edmondson Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Alexander Va.	Mar. 12/21 19....
20-UNDERTAKER	ADDRESS
Wm Cook.	502 E North Ave.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 51760 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51760

CERTIFICATE OF DEATH.

REGISTERED No. C 108

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland Gen. Hosp. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kuhn

(Residence in Baltimore: No. 1079 W. Fayette St. 52 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, Feb. (Month) 16 (Day), 1869 (Year)

7-AGE, 52 yrs. mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: clothing cutter
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob Kuhn

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Kathryn Adams

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Kuhn

(Address) 1079 W. Fayette St.

15- Filed ....., 191.... Robert P. Harrison, Burial Permit Clerk, Registrar.

MAR 12 1921

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis (due to rupture of appendix)

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) appendicitis

(Duration) ....yrs. ....mos. 4 ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

March 10, 1921 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1079 W. Fayette St.

Former or usual residence 1079 W. Fayette St.

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery DATE OF BURIAL, Mar. 12, 1921

20-UNDERTAKER Harry H. Fitzke ADDRESS 531 W. Lombard St.

D-51761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-51761

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2620 Fleet ST. 1 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madeline Dembeck

(Residence in Baltimore: No. 2620 Fleet St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Dec 5, 1919
(Month) (Day) (Year)

7-AGE. 1 yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Anthony Dembeck

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Golembieska

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Dembeck

(Address) 2628 Fleet St

15- Filed MAR 12 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Pneumonia

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs.....mos.....ds.

(Signed) M. D. Kinsler (Coroner.) M. D.

....., 191.. (Address) 1805 Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Stanislaus Cem	Mar 12 1921

20-UNDERTAKER Stephen J. Fialkowski ADDRESS 1100 S Kenwood

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51762 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51762

CERTIFICATE OF DEATH.

8

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

2-FULL NAME Frances Meyers.

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ernest Meyers.

6 DATE OF BIRTH (month, day, and year) Feb 1 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Martin Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Rosina —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Sister Florence, (Address) Little Sisters of the Poor.

15 Filed MAR 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17

I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19...

that I last saw her alive on March 5 1921,

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Mother

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of left thigh

(duration) 4 mos. 2 days age 77 yrs.

18 Where was disease contracted if not at place of death? (Little Sisters of the Poor)

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

March 11, 1921 (Signed) Baltimore, M. D. (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 14 1921
20 UNDERTAKER	**ADDRESS**
Henry Hoch & Son	1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

D.51763 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51763

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N Mount St ST.; 19 WARD)

REGISTERED No. C 89

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Fennell Sr

(Residence in Baltimore: No. 509 N Mount St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Widower

6-DATE OF BIRTH, Dec 24 1854
(Month) (Day) (Year)

7-AGE, 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, Major Fennell

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md

12-MAIDEN NAME OF MOTHER Catharine Jones

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Fennell

(Address) 1509 Druid Hill Ave

15- Filed MAR 12 1921, 191

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 9, 1921.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Dec 24 21 191, to Mar 8-21 191, that I saw h ill alive on Mar 9, 1921, and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Acute Mania Chronic

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis Senility

(Duration) 2 yrs. mos. ds.

(Signed) F McCardozo M. D.

3-11-21 191... (Address) 1524 N Hilldale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Mar 12, 1921.
20-UNDERTAKER	ADDRESS
Samuel T Hunley	678 N Bridle

If any item of information is not known, say so. Every item of information must be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.51764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51764

42

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie Josephine McNabb

(Residence in Baltimore: No. 4 N. Fulton Ave St.; 28 yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, August (Month) 10 (Day), 1892 (Year)

7-AGE, 28 yrs. 7 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or estsblishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Albert McNabb

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co. Maryland

12-MAIDEN NAME OF MOTHER Mary Ellen Graham

13-BIRTHPLACE OF MOTHER (State or Country), Virginia, Staunton

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert McNabb,

(Address) 4 N. Fulton Ave.

15-

Filed.....Robert P. Harrison..... Registrar.

MAR 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 23 1921, to March 11 1921, that I saw h.r alive on March 11. 1921; and that death occurred, on the date stated above, at 1.20 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (?) (1)

Lob. oram

Post Operative Metastasis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) ..... (Duration) yrs. 2+ mos. ds.

(Signed) H. Lloyd Johnson M. D.

....., 191... (Address) Bon Secours Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. ds. In the State 28 yrs. 7 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 4 N. Fulton Ave

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Mar. 14, 1921.

20-UNDERTAKER H. Offutt, Jr.

ADDRESS 322 S. Payson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

20.51765 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51765

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 N Carey ST.; 16 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Wiggins

(Residence in Baltimore: No. 1026 N Carey St.; 7 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, Unknown (Month), (Day), 1869 (Year)

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Born in Balt-3 years Virginia

PARENTS.

10-NAME OF FATHER, Not given

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Wat

(Address) 1026 N Carey St.

15-

Filed Mar 12 1921 Robert P. Harrison, Registrar.

MAR 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar- 10 (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb- 1- 1921, to Mar 10 1921, that I saw h[illegible] alive on Mar 10 1921, and that death occurred, on the date stated above, at 1:10 p m.

The CAUSE OF DEATH* was as follows:

a. Uremia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) ac Nephritis

(Duration) yrs. 1 mos. ds.

(Signed) Chas Short M. D.

Mar 10 1921. (Address) 16 E Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Hurlum Cem	March 12, 1921
20-UNDERTAKER Chas R A Elliott	ADDRESS 1723- Ashland Ave

N. B.—Every item of information must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D-51766

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-51766

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 S. Schroder. St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Leo. McHugh

(a) RESIDENCE. No. 110 S. Schroder. St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 13th 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker asst.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer B+O. R.R. Baltimore

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER James. McHugh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret Coady

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Mary King.
(Address) 110 S. Schroder.

15 Filed MAR 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16- 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 1921, to March 16 1921, that I last saw him alive on March 9 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

3 months under my care

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Dyspepsia Chronic

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tubercle bacilli in sputum

(Signed) John J. Young, M. D.

Mar 11, 1921 (Address) 904 N. Schroder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cty.	Mar 14th 1921
20 UNDERTAKER	ADDRESS
John L. Moran	3000 E. Balto.

...mation should be carefully supplied. ...AGE should be stated in years. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51767 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51767

CERTIFICATE OF DEATH.

6-09

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1214 Glyndon Ave. ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James M Smith Sr

(a) RESIDENCE. No. 1214 Glyndon Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER James M. Smith

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Balto

12 MAIDEN NAME OF MOTHER Lena Musgrove

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant James M Smith
(Address) 1214 Glyndon Ave

15 Filed Robert P. Harrison, Registrar

MAR 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/21 19

17 I HEREBY CERTIFY, That I attended deceased from 3/10/21, 19..., to 3/11/21, 19..., that I last saw h— alive on 3/11/21, 19..., and that death occurred, on the date stated above, at 2 4 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Measles,

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Rein, M. D.

, 19 (Address) 1202 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 12 1921
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20.51768

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 Mosher ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Willis

(a) RESIDENCE. NO. 633 Mosher ST., WARD. Wheeling W. Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) dont know 1915

7 AGE 6 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER W. D. Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vicksburg Mississippi

12 MAIDEN NAME OF MOTHER Lizzie Wooten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vicksburg Miss

14 Informant Rev. Dr. Guy

(Address) 1136 Eutaw Pl

15 Filed MAR 12 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9/21 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 5th, 1921, to Mar 9, 1921, that I last saw him alive on 3/7/21, 19, and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Gastric Tuberculosis

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 633 Mosher St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R Boyd Kerr M. D.

, 19 (Address) 1380 N Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Mar 12 19

20 UNDERTAKER: Edward Ringgold — ADDRESS: 1463 Carey

AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51769 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51769

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 W. Chase St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Bush

(a) RESIDENCE. No. 212 W. Chase ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
54		—	—	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Bush

(Address) 1516 Brunt St

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10-1921

17 I HEREBY CERTIFY, That I attended deceased from 3-8-, 1921, to 3-10, 1921, that I last saw h.r alive on 3-10-, 1921, and that death occurred, on the date stated above, at 12,31 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. D. Haigh, M. D.

3-10, 1921 (Address) 611 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar. 13 1921

20 UNDERTAKER Edward Ruggold ADDRESS 1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51770 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51770

CERTIFICATE OF DEATH. 88

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Office ST.: 14 WARD)

2-FULL NAME Mrs. ~~Frank~~ Pippin

(a) RESIDENCE. No. Roan Mountain Tenn ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Mr. Frank Pippin

6 DATE OF BIRTH (month, day, and year) April - 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Wm Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Katharine Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Mrs Minnie Woodruff

(Address) S Toll Creek Tenn

15 Filed Robert P. Harrison Registrar

MAR 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to March 11, 1921, that I last saw her alive on March 11, 1921, and that death occurred, on the date stated above, at 12 40 p. m.

The CAUSE OF DEATH* was as follows:

(Coutre) Post Op. Shock.

(Coutre) (duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post Op. Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Tenn.

Did an operation precede death? Yes Date of March 11-21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Geo. E. W. Haldy, M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Roan Mountain Tenn	Mch 12 1921
20 UNDERTAKER	ADDRESS
J Herwig & Co	2005 Arlington

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20.51771 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51771

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 15 1/2 Rossbach Court. ST.: 22 1/20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Muscoe Vessels.(C)

(Residence in Baltimore: No. 15 1/2 Rossbach Court. St.; 30 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	Colored.	Widower.

6-DATE OF BIRTH, ... Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
48 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer. 0 to 10
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER. William Vessels.(C)

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Kate Campbell.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan Waters.(C) sister.

(Address) 15 1/2 Rossbach Court.

15- Filed MAR 12 1921, 191.....
Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.)
inquiry ..... find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
Chronic Interstitial Nebhritis.
.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

March 11 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn ct	March 13, 19 21
20-UNDERTAKER	ADDRESS
C. E. Brown & Son	1011 W. Monty st

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51772 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51772

CERTIFICATE OF DEATH. 152

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1302 Mett ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Despar

(a) RESIDENCE. NO. 1302 Mett ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 7, 1921

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Julius Despar

11 BIRTHPLACE OF FATHER (city or town) Ga.
(State or country)

12 MAIDEN NAME OF MOTHER Delia Nash

13 BIRTHPLACE OF MOTHER (city or town) Ga.
(State or country)

14 Informant D. Gamble MD.
(Address)

15 Filed MAR 12 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1921, to March 7, 1921, that I last saw him alive on March 6, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Haemorrhagic Disease of Newborn

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy N. Cromwell, M. D.

3/10, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: MAR 11 1921

20 UNDERTAKER: Commissioner Health. — ADDRESS

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51773

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51773

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anastorcas Aropislas

(a) RESIDENCE. No. 1712 Thames st. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Geo. Aropislas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Records (Address) M.T.H.

15 Filed ....., 19.... Robert P. Harrison, Registrar

MAR 12 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1920, to March 8, 1921, that I last saw h.... alive on March 7, 1921, and that death occurred, on the date stated above, at 5.35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. D. Digney, M. D.

3-8-21. 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health, WOODALL.

MAR 1 7 1921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51774 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51774

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Williams

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1815

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address) New City Hospital

15 Filed MAR 12 1921, 19 Robert P. Harrison, Registrar

Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK. PENCIL NOT ACCEPTABLE. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified

D.51775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51775

CERTIFICATE OF DEATH.

Registered No. C 64

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 708 Woodyear St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha E. Harris.

(Residence in Baltimore: No. 708 Woodyear St. St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, November, 1859
(Month) (Day) (Year)

7-AGE, 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 0 0

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Alexander Carter

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Florence Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Dennis

(Address) 1303 Presstman St.

15- Robert P. Harrison,

Filed ..... 191.....

MAR 12 1921 Burial Permit [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Jury
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

1/2 hr.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. mos. ds.

(Signed) J. E. D. Hennessy M. D.
(Coroner.)

March 11, 1921. (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn. | DATE OF BURIAL, Mar. 12, 1921.

20-UNDERTAKER James H Dennis | ADDRESS 1303 Presstman St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.51776 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51776

CERTIFICATE OF DEATH.

92 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Stilsley

(a) RESIDENCE. No. St. Mary's Industrial School WARD. Norfolk Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20-1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va.

PARENTS

10 NAME OF FATHER Dead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do Not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do. Not. Know

14 Informant Brother, Paul (Address) St. Marys Industrial school

15 Filed Robert P. Harrison, Registrar

MAR 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-11 - 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-1-, 1921, to 3-11, 1921, that I last saw him alive on 3-11, 1921, and that death occurred, on the date stated above, at 11 32 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death? St Mary's industrial

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Winfield N. Craig, M. D.

, 19 (Address) St Agnes H. Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL Mar 12" 1921

20 UNDERTAKER Chas F. Evans & Son — ADDRESS 118 West Royal Ave

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51777 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51777

CERTIFICATE OF DEATH. 10-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera Apt ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Putzel

(a) RESIDENCE. NO. Lake Drive ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Tillie B. Putzel

6 DATE OF BIRTH (month, day, and year): May 2nd 1857

7 AGE: Years 64 Months 7 Days 9 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Silver Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Selig B. Putzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Lindheim

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Putzel

(Address): Same

15 Filed Mar 14 1921 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 11th 1921

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1921, to Mar. 11, 1921, that I last saw h.... alive on March 11, 1921, and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Acute Bright's

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) La Grippe, Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Louis G. Mayer M. D.

3/11. 1921 (Address) 3438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Har Sinai Cem	Mch. 14 1921
20 UNDERTAKER	ADDRESS
Harry Sondheim	1 E Lexington St

Burial Permit Clerk.

TAKE OF DEATH on plain white paper, without seal. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51778 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51778

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 West 24th St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Burroughs

(a) RESIDENCE. No. 5 W. 24th St. Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M Burroughs

6 DATE OF BIRTH (month, day, and year) August 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10 NAME OF FATHER Thomas S Burroughs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susan Cushe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mary M Burroughs 5 W 24

15 Filed ( ), 19.....

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 4, 1921, to Nov 12, 1921, that I last saw h in alive on Nov 11, 1921, and that death occurred, on the date stated above, at 5.45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin F. Hagerty, M. D.

11/22, 1921 (Address) 1438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Worcester Mass	Mar 14 1921
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

10.51779

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.51779

CERTIFICATE OF DEATH.

150

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3827 Cliftonave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabel Leidy

(Residence in Baltimore: No. 3827 Clifton St.; ....yrs., ...mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White.	Single

6-DATE OF BIRTH, Feb 22th (Month), (Day), 1921. (Year)

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 17 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William H. Leidy.

11-BIRTHPLACE OF FATHER (State or Country), Denver, Col.

12-MAIDEN NAME OF MOTHER Mae E Pettit

13-BIRTHPLACE OF MOTHER (State or Country), Williamsport Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H Leidy.....

(Address) 3827 Clifton Ave.....

15- Robert P. Harrison,

Filed....., 191.....

MAR 12 1921 Burial Permit Clerk, Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 11 (Month), (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 27 1921, to Mar 11 1921, that I saw h er alive on Mar 11 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(Duration).....yrs.....mos. 17 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos. 7 ds.

(Signed) W. O. Thomas M. D.

Mar 12 1921 (Address) 1228 N Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Mar 12, 1921.

20-UNDERTAKER Wm J Tickerton. ADDRESS N Y Pa

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51780 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.51780

CERTIFICATE OF DEATH. 91-089

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 135 Wildemette ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Johnson

(a) RESIDENCE. No. 135 W. Hemiller ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 30 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Viola Banster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James Johnson
(Address) 135 W. Hemiller St

15 Filed MAR 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 8 1924, to Mar 10 1924, that I last saw h[illegible] alive on Mar 10 1924, and that death occurred, on the date stated above, at 10.10 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Auto Bronchitis
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Cunnell, M. D.

3/12 1924 (Address) 140 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn St	Mch 12 1924
20 UNDERTAKER	ADDRESS
H. W. Brown & Son	1081 W. Monroe

CAUSE OF DEATH to be plainly written, and that TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D. 51781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51781

CERTIFICATE OF DEATH.

41

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1815 N. Charles ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie C. McRae

(a) RESIDENCE. NO. 1815 N. Charles ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William B. McRae

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Sigmund

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Meyer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant George McRae

(Address) 1815 N. Charles Street

15 Filed Robert P. Harrison, Registrar

R 12 1921 Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 10 1921

17 I HEREBY CERTIFY, That I attended deceased from January 19 19, to Mch 10, 1921, that I last saw h. alive on Mch 8 1921, and that death occurred, on the date stated above, at 11.10 pm.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Defective Echocardium

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N

Did an operation precede death? Yes Date of Nov - 1919

Was there an autopsy? No

What test confirmed diagnosis? Tissue exam

(Signed) Chas F Bloke, M. D.

Mch 11 1921 (Address) 204 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: 3/14 1921

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51782 HEALTH DEPARTMENT—CITY OF BALTIMORE D51782

CERTIFICATE OF DEATH. 50

REGISTERED NO.:.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3012 St. Paul ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. J. Carey

(a) RESIDENCE. No. 3012 St. Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth M Carey

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick Carey

11 BIRTHPLACE OF FATHER (city or town) Galway
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Mahoney

13 BIRTHPLACE OF MOTHER (city or town) Galway
(State or country) Ireland

14 Informant Julian J. Carey
(Address) 1900 Belair Road

15 Filed MAR 12 1921 16 Robert P. Harrison Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11- 1921

17 I HEREBY CERTIFY, That I attended deceased from August 9th, 1920, to March 11-, 1921, that I last saw h in alive on March 10, 1921, and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -
Diabetes -

(duration) Many yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Paralysis -
(duration) about 8 yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) [illegible], M. D.

, 19 (Address) 1327 Park Ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	3/14 1921
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

CAUSE OF DEATH must be filled in plainly, so that a proper CERTIFICATE may be issued. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51783

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51783

CERTIFICATE OF DEATH.

137

REGISTERED NO.....

1-PLACE OF DEATH S. Balto. Gen. Hosp.

CITY OF BALTIMORE: (NO. ~~1833 E. Eager~~ ST.: 7 : WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katherine Seipp.

(a) RESIDENCE. NO. 1833 E. Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married.

5a If married, widowed, or divorced (or) WIFE of Calvert Seipp

6 DATE OF BIRTH (month, day, and year) July 15, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Conrad Lewis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary J. Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Conrad Lewis 1833 E. Eager st

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to March 11, 1921, that I last saw her alive on March 11, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia following childbirth.

Etiology unknown as yet (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Endometritis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1833 E. Eager St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cultures taken.

(Signed) L. C. Dolinal, M. D.

.19 (Address) S. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Mch 14 1921

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 Eager

12 1921

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51784 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51784

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No Tudor Hall Apts ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Dukes

(a) RESIDENCE. NO University Parkway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Otto Dukes.

6 DATE OF BIRTH (month, day, and year) 1837-11-28

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Fritsch N. Raddecke

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Sophia Weddemeyer

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Wm. Fr. W. Dieckle (Address) Tudor Hall

15 Filed MAR 12 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1920, to Mar 11, 1921, that I last saw her alive on Mar 10, 1921, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Erwin F. Krieger, M. D.

3/12 1921 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3-14 1921
20 UNDERTAKER Emory V. Cutting & Sons Co	ADDRESS Hilltop Orchard

CAUSE OF DEATH in plain terms, so that a ... TION is very important. See instructions on ba...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51785 — HEALTH DEPARTMENT—CITY OF BALTIMORE. — D 51785

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4507 Frederick Ave. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Baifell

(a) RESIDENCE. NO. 4507 Frederick Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M Baifell

6 DATE OF BIRTH (month, day, and year) Jan 20 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob G Baifell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hodson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Charles E Baifell 4507 Frederick Ave

15 Filed MAR 13 1921 ROBERT J. KRAUSE Registrar

16 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July 16 1920, to March 12 1921, that I last saw him alive on March 10 1921, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. 7 mos. 24 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Bartlett, M. D.

, 19 (Address) 1540 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M C Clark	Mar 15 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Balto

CAUSE OF DEATH must be stated plainly. Indefinite terms, such as "Heart Failure," "Old Age," "Paralysis," "Convulsions," "Cancer," "Tumor," "Abscess," "Child-bed," "Fever," "Inflammation," "Hemorrhage," "Dropsy," "Debility," "Premature Birth," "Malformation," "Stillborn," "Suffocation," "Asphyxia," "Coma," "Uremia," "Septicemia," "Pyemia," "Meningitis," "Peritonitis," "Pneumonia," "Bronchitis," "Pleurisy," "Nephritis," "Hepatitis," "Enteritis," "Colitis," "Gastritis," "Appendicitis," "Cystitis," "Arthritis," "Rheumatism," "Neuralgia," "Hysteria," "Epilepsy," "Insanity," "Senility," "Marasmus," "Exhaustion," "Shock," "Collapse," "Syncope," "Apoplexy," "Embolism," "Thrombosis," "Aneurism," "Rupture," "Laceration," "Contusion," "Fracture," "Wound," "Burn," "Scald," "Drowning," "Electrocution," "Poisoning," "Accident," "Homicide," "Suicide," "Unknown," "Undetermined," "Not Known," "Not Stated," "Not Specified," "Not Diagnosed," "Not Ascertained," "Not Known to Informant," "Not Known to Physician," "Not Known to Coroner," "Not Known to Undertaker," "Not Known to Embalmer," "Not Known to Sexton," "Not Known to Gravedigger," "Not Known to Cemetery Superintendent," "Not Known to Crematory Superintendent," "Not Known to Funeral Director," "Not Known to Undertaker's Assistant," "Not Known to Embalmer's Assistant," "Not Known to Sexton's Assistant," "Not Known to Gravedigger's Assistant," "Not Known to Cemetery Superintendent's Assistant," "Not Known to Crematory Superintendent's Assistant," "Not Known to Funeral Director's Assistant," "Not Known to Undertaker's Assistant's Assistant," "Not Known to Embalmer's Assistant's Assistant," "Not Known to Sexton's Assistant's Assistant," "Not Known to Gravedigger's Assistant's Assistant," "Not Known to Cemetery Superintendent's Assistant's Assistant," "Not Known to Crematory Superintendent's Assistant's Assistant," "Not Known to Funeral Director's Assistant's Assistant," "Not Known to Undertaker's Assistant's Assistant's Assistant," "Not Known to Embalmer's Assistant's Assistant's Assistant," "Not Known to Sexton's Assistant's Assistant's Assistant," "Not Known to Gravedigger's Assistant's Assistant's Assistant," "Not Known to Cemetery Superintendent's Assistant's Assistant's Assistant," "Not Known to Crematory Superintendent's Assistant's Assistant's Assistant," "Not Known to Funeral Director's Assistant's Assistant's Assistant," "Not Known to Undertaker's Assistant's Assistant's Assistant's Assistant," "Not Known to Embalmer's Assistant's Assistant's Assistant's Assistant," "Not Known to Sexton's Assistant's Assistant's Assistant's Assistant," "Not Known to Gravedigger's Assistant's Assistant's Assistant's Assistant," "Not Known to Cemetery Superintendent's Assistant's Assistant's Assistant's Assistant," "Not Known to Crematory Superintendent's Assistant's Assistant's Assistant's Assistant," "Not Known to Funeral Director's Assistant's Assistant's Assistant's Assistant," "Not Known to Undertaker's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Embalmer's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Sexton's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Gravedigger's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Cemetery Superintendent's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Crematory Superintendent's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Funeral Director's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Undertaker's Assistant's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Embalmer's Assistant's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Sexton's Assistant's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Gravedigger's Assistant's Assistant's Assistant's Assistant's Assistant's Assistant," "Not Known to Cemetery Superintendent's 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Known to Sexton's Assistant," "Not Known to Gravedigger's Assistant," "Not Known to Cemetery Superintendent's Assistant," "Not Known to Crematory Superintendent's Assistant," "Not Known to Funeral Director's Assistant," "Not Known to Undertaker's Assistant," "Not Known to Embalmer's Assistant," "Not Known to Sexton's Assistant's Assistant's Assistant's Assistant's Assistant's Assistant's Assistant's Assist

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51786 HEALTH DEPARTMENT—CITY OF BALTIMORE D51786

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 718 Fork Ave ST.: 27 91 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose V. Warfield

(a) RESIDENCE. NO. 718 Fork Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 9. 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John W. Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Maggie Manning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant J. W. Warfield
(Address) 718 Fork

15 Filed MAR 13 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from March. 8, 1921, to March 10, 1921, that I last saw her alive on March 10, 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

3/11, 1921 (Address) 638 Fork

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	March 14 1921
20 UNDERTAKER William Cook	ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be readily understood. Do not use abbreviations or technical terms. Consult the Physician if necessary. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51787 HEALTH DEPARTMENT—CITY OF BALTIMORE D51787

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH Robt Garrett Hosp

REGISTERED NO.

CITY OF BALTIMORE: (No. 27 N. Carey ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Astin

(a) RESIDENCE. NO. 412 E 26th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - Md

PARENTS

10 NAME OF FATHER Julian Astin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Harriett Blackman
(Address) 318 E [illegible] St

15 MAR 13 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17

I HEREBY CERTIFY, That I attended deceased from March 5 1921, to March 12 1921, that I last saw her alive on March 12 1921, and that death occurred, on the date stated above, at 2 A.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) [illegible], M. D.

3/12 1921 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys - Hampden	March 14 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. Monta

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51788

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51788

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Tuberculosis Hospital St. 26 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Sacks

(a) RESIDENCE. No. O'Donnell & 16th sts. St.. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

060

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER John Sacks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Rickie Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records

(Address) M.T.H.

15 FILED MAR 13 1921 BOYER S. FRAUTEN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1920, to March 12, 1921, that I last saw him alive on March 11, 1921, and that death occurred, on the date stated above, at 4.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. S. Fahndrich, M. D.

3-12-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel.	May 15 1921
20 UNDERTAKER	ADDRESS
Cowdrick	502 E Madison

CAUSE OF DEATH must be plainly written, and all questions answered. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51789 HEALTH DEPARTMENT—CITY OF BALTIMORE D51789

CERTIFICATE OF DEATH. X 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Cummins

(a) RESIDENCE. No. Freeland R.F.D.-2nd ST., WARD. Freeland Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be intelligible to a person not a physician. See back of certificates. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24-1913

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	7	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Cummins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Ehrman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Hospital Record

(Address) J. H. H.

15 MAR 13 1921 16 ROBERT J. KRAUTER Registrar

Burial Permit Issued

Via PRR. C/o Jacob Cummins.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12-1921

17

I HEREBY CERTIFY, That I attended deceased from March 11-, 1921, to March 12-, 1921, that I last saw her alive on March 12-, 1921, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James E. Fop, Jr. M. D.

3/17/21 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bentley Springs Md.	Mar 13 1921
20 UNDERTAKER	ADDRESS
Wm Cook.	502 E. North Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51790

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Arrington

(a) RESIDENCE. NO. 738 Bartlett ST. Av. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo Arrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Martha Frazer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Geo. Arrington.
(Address) 738 Bartlett Ave.

15 FILED MAR 13 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12 1921

17

I HEREBY CERTIFY, That I attended deceased from 3-1-, 1921, to 3-12, 1921,

that I last saw him alive on 3-12, 1921,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Hernia Strang

(duration) ....yrs. ....mos. 11 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) ....yrs. ....mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-2-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm C Craig, M. D.

(Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill cem Wash. DC	Mar 14 1921

20 UNDERTAKER	ADDRESS
Cruikshank	502 E North Ave

c/o F. A. Vandenburgh Via Brokaw

CAUSE OF DEATH must be given by physician, coroner or other person. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Strangulated
Lobar Pneumonia
Primary.

D51791 HEALTH DEPARTMENT—CITY OF BALTIMORE D51791

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5229 Parkheights Ave. WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Lanham.

(Residence in Baltimore: No. 5228 Parkheights Ave. St.; 18 yrs., mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Dec. (Month) 3 (Day), 1869 (Year)

7-AGE: 51 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Washington D. C.

PARENTS.

10-NAME OF FATHER: Robert Lanham

11-BIRTHPLACE OF FATHER (State or Country): Washington D. C.

12-MAIDEN NAME OF MOTHER: Mary E. Beach

13-BIRTHPLACE OF MOTHER (State or Country): Washington D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. T. Saddler

(Address) 5225 Park Heights Ave

15- [redacted]

Filed MAR 13 192[redacted] Burial Permit [redacted]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) John Morrison M. D.

(Coroner) 1932 Roland Ave (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Washington D C

DATE OF BURIAL: Mond. 3/14/21

20-UNDERTAKER: A. Jones

ADDRESS: 207 E. Stricker

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D51792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51792

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 Mosher St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilhelmina Smith

(Residence in Baltimore: No. 1624 Mosher St. St.; 59 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ....., 1..... (Day) (Year)

7-AGE, ..58.. yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laundry

9-BIRTHPLACE, (State or Country), Lie in Baltimore 39 years
reton Shore Md.

PARENTS.

10-NAME OF FATHER, James Lake

11-BIRTHPLACE OF FATHER (State or Country), born in Md

12-MAIDEN NAME OF MOTHER Sarah Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Smith

(Address) 1624 Mosher St

15- MAR 13 1921 [illegible] & [illegible]

Filed....., 191... Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1921, to March 10, 1921, that I saw her alive on March 10, 1921, and that death occurred, on the date stated above, at 7:40 a m.

The CAUSE OF DEATH* was as follows: Mitral regurgitation

..... (Duration) ....yrs. 3 mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs.....mos.....ds.

(Signed) Jno. A. Robinson M. D.

3/11, 191.. (Address) 1520 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oakley Cem

DATE OF BURIAL, March 13, 191...

20-UNDERTAKER Mrs R A Elliott

ADDRESS 725 Ashland Av

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D51793 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51793

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 N. Dallas ST.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith E. Smith

(Residence in Baltimore: No. 1620 N. Dallas St.; 11 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Sept 22 (Month) 22 (Day) 1919 (Year)

7-AGE, 2 yrs. 1 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Phindelle Smith

11-BIRTHPLACE OF FATHER (State or Country), Lancaster Co Va

12-MAIDEN NAME OF MOTHER Katie Luckly

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. Xanthus Phindelle Smith

(Address) 1620 N Dallas St

15- MAR 13 1921 ROBERT E KRAUTER Registrar.
Filed....., 191... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1921, to March 11 1921, that I saw h-er alive on March 11, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Gastro-enteritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Gastric Catarrh

(Duration) 2 yrs. mos. ds.

(Signed) Jacob Obrecht M. D.

3/11, 1921 (Address) 1520 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cem — DATE OF BURIAL, March 13 1921

20-UNDERTAKER Wm R & Elliott — ADDRESS 1725 Aisquith

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51794 HEALTH DEPARTMENT—CITY OF BALTIMORE D51794

CERTIFICATE OF DEATH.

34

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 Rueckert Av. Hamilton, ST. 27 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie J. Schwartz

(a) RESIDENCE. No. 34 Rueckert Av. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry C. Schwartz

6 DATE OF BIRTH (month, day, and year): Jan 3rd 1881

7 AGE: 40 Years | 2 Months | 7 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William Marley.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Caroline E. Leather

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Henry C. Schwartz

(Address): 34 Rueckert Ave

15 MAR 13 1921 REGISTERED

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1921, to Mar 18, 1921, that I last saw h.. alive on Mar 10, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of Kidney & Bladder (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Cystoscope

(Signed) Clara Simms, M. D.

(Address) 1786 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Paul Cemetery Valleville. DATE OF BURIAL: March 14 1921

20 UNDERTAKER: C. W. Dill ADDRESS: 3109 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or terms peculiar to physicians. Information required in items 16 to 20 may be given by physician, undertaker, or other person having knowledge of the facts. Items 1 to 15 must be given by informant. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51795 HEALTH DEPARTMENT—CITY OF BALTIMORE D51795

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 913 Ellwood ST.: 1 WARD)

2-FULL NAME Caroline Green

(a) RESIDENCE. No. 913 Ellwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Green

6 DATE OF BIRTH (month, day, and year) June - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Zeigler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Friedenwald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Green

(Address) 913 Ellwood Ave.

15 FILED MAR 13 1921 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to March 11, 1921.

that I last saw her alive on March 11, 1921.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Mitral & aortic Insufficiency (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. H. McAvoy, M. D.

3/13, 1921 (Address) 839 S. Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 14 19
20 UNDERTAKER	ADDRESS
Wendell Lippel & Son	37 S. Am

CAUSE OF DEATH must be filled in plainly, so that it can be understood by any physician. See reverse side of certificates.

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51796

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH US. Public Health Hosp. #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo, Percy, Willaims 1361 Carroll st

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST McHenry Road Baltimore Md.
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of (Wife) Mrs Percy Willaims

6 DATE OF BIRTH (month, day, and year) Unknown 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33 yrs	--	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work day-laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ---
(c) Name of employer ---

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Horatio Williams
~~unknown~~

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Mrs Williams Registrar
(Address) US. PHS. McHenry Baltimore Md.

15 MAR 13 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to March 10, 1921, that I last saw him alive on March 10, 1921, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary Active.)

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ----

Was there an autopsy? No

What test confirmed diagnosis? Exam. Clinic Report

(Signed) Thomas R. Byrne M. D.

, 19 (Address) US. PHS HOSP #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt auburn Cmty	3/13 1921
20 UNDERTAKER	ADDRESS 215 N Pine St
Mrs Chas B Jones	

CAUSE OF DEATH in plain words. Physician's or midwife's certificate must be filed with the Registrar of Vital Statistics before a burial permit is issued. Every question on this certificate must be answered if possible. Special attention is called to the question of occupation, which is very important. See instructions on back of certificates.

Pearl Milzman

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51797

D51797

CERTIFICATE OF DEATH.

x 92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1103 Harlem ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearel Milzman

(a) RESIDENCE. NO. 1103 Harlem ave ST., WARD. Russia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	maried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Milzman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1411 E. Baltimore St

15 FILED MAR 13 1921 BOLEY'S LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 12, 1921, that I last saw h... alive on March 12 1921, and that death occurred, on the date stated above, at 415 am

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) x Henry Glassman, M. D.

Mar 12 1921 (Address) 2682 Westlake Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehrem Memorial	3/13 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Baltimore St

CAUSE OF DEATH in plain terms. Name of disease alone is not sufficient. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D51798 HEALTH DEPARTMENT—CITY OF BALTIMORE D51798

CERTIFICATE OF DEATH. 79-041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Chauncey Ave ST. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah Mollie Klein

(a) RESIDENCE. NO. 922 Chauncey Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Klein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1411 E. Balto st

15 Filed MAR 13 1921 ROBERT A. KRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from March. 9, 1921. to March. 12, 1921. that I last saw h[illegible] alive on March. 11, 1921. and that death occurred, on the date stated above, at 5 30 9 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease (Mitral Insuff.) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Williams Kelley, M. D.

. 19 (Address) 2327 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Ave	3/13 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto. Street

CAUSE OF DEATH must be plainly written. Do not use abbreviations. Consult physician if necessary. Any additional facts known should be given. Information required by this certificate is necessary for the protection of life and property. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51799 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51799

CERTIFICATE OF DEATH. 78

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 425 Calvin ave ST.: 12 WARD)

2-FULL NAME John F. Conroy.

(a) RESIDENCE, NO. 425 Calvin Ave ST., 12 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie B Conroy.

6 DATE OF BIRTH (month, day, and year) Jan 6 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hat Blocker

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Patrick Conroy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie B Conroy.
(Address) 425 Calvin ave

15 Filed MAR 13 1921 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6 1921, to Mar. 11 1921, that I last saw h/im alive on March 10 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis awn

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? As usual in such cases.

(Signed) Thos. Dillsbury, M. D.

, 19 (Address) 1602 E. 27th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 14 1921
20 UNDERTAKER	ADDRESS
E. A. Wendfeld Jr	601 E 22

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates.
TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

could give no other cause

Azille Gray.

Spec.—6-9-19—H. P. Co.—1000 Bks.

951800 HEALTH DEPARTMENT—CITY OF BALTIMORE 951800

CERTIFICATE OF DEATH. + 91

1-PLACE OF DEATH Mercy Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... St.: 4 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Azille Gray.

(a) RESIDENCE. NO. Mercy Hosp. ST., ... WARD. Catonsville Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 20, 1918

7 AGE: Years 3 Months 1 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Dr

9 BIRTHPLACE (city or town) (State or country) Catonsville Balto. County

PARENTS

10 NAME OF FATHER Charles M. Gray

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Harwood

13 BIRTHPLACE OF MOTHER (city or town) Harwood (State or country) Baltimore Co Md

14 Informant Charles M Gray (Address) 15-2 Winter ave

15 MAR 13 1921 ROBERT E KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 5, 1921, to Mar 12, 1921, that I last saw h alive on Mar 12, 1921, and that death occurred, on the date stated above, at 10.40 A m.

The CAUSE OF DEATH* was as follows:

Bronchis Pneumonia

two weeks
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. O. Ridgely, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisontown Cemetery	March 14 19

20 UNDERTAKER ADDRESS

Edward W. Rye Catonsville Md

CAUSE OF DEATH. The primary cause of death must be stated. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51801

CERTIFICATE OF DEATH.

41

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Edmonson Ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise. M. Wallace

(a) RESIDENCE. NO. 1102 Edmonson Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. c mos. c ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed,~~ or ~~Divorced (write the word)~~
Female	white	Married

3a If married, widowed, or divorced HUSBAND) of (or) WIFE of Shayler. R. Wallace

6 DATE OF BIRTH (month, day, and year) March 9 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	c	c	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Francis Buschmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Martha Balz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Shayler. R. Wallace
(Address) 1102 Edmonson Ave

ROBERT A. LEITCH
Registrar

15 Filed MAR 13 1921, 19 Burial Permit 9764

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to March 10, 1921, that I last saw h[illegible] alive on March 9, 1921, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - rectum
Metastasis Ileration
Abscess. fecal fistula

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Bronchitis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7 mos ago

Was there an autopsy? no

What test confirmed diagnosis? microscopical

(Signed) Francis P. Buchio M.D., M. D.

, 19 (Address) 904 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	March 14 1921
20 UNDERTAKER	ADDRESS
for Joerdens Son	217 S. Paca

CAUSE OF DEATH in plain terms, so that a person not a physician may understand it. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51802

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51802

42

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S Exeter St.: 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Dr Angelo

(a) RESIDENCE. No. 414 S Exeter St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Dr Angelo

6 DATE OF BIRTH (month, day, and year) Nov. 22 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Francis Romeo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine De Rollis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Anthony Dr Angelo (Address) Hill & Exeter Sts

15 Filed MAR 13 1921 ROBERT F. KRAUTZ Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1920, to Mar 12, 1921, that I last saw her alive on Mar 11, 1921, and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Cancer Uterine (Cervix)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 16/20

Was there an autopsy? no

What test confirmed diagnosis? ---

(Signed) Neil L. Arbaugh, M. D.

, 19 (Address) 1634 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Mar 15 1921
20 UNDERTAKER	ADDRESS
Wendell Dippel & Son	37 S Mar

CAUSE OF DEATH to be written in plain terms, so that a non-medical person can understand it. Do not use abbreviations or ditto marks. Be particular and definite. Do not say "Accident," "Fracture," "Disease of Heart," "Cancer," "Tumor," "Abscess," "Child," "Stillborn," "Old Age," or "Unknown." If from accident, violence, or casualty, state the nature, and whether it was suicidal, homicidal, or accidental. If a woman, state whether single, married, widowed, or divorced. If death occurred during childbirth, state the fact. If deceased was not a resident of the city, give usual residence. The space for "Cause of Death" should not be used for modes of dying, such as "Heart Failure," "Asthenia," "Exhaustion," "Cardiac Syncope," "Respiratory Arrest," "Uremia," "Coma," etc., unless they are the only terms which can be assigned. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51803

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8038 Lakewood ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy V. Gagodeinski

(a) RESIDENCE. NO. 8038 Lakewood Av. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 6 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	6	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Stephen Gagodeinski

11 BIRTHPLACE OF FATHER (city or town) Balt
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Pinchinat

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant Stephen Gagodeinski
(Address) 8038 Lakewood

15 MAR 13 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to March 12, 1921, that I last saw h[illegible] alive on March 12, 1921, and that death occurred, on the date stated above, at 10:10 a m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

M. B. 1921 (Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Trappe Rd.	March 14 1921
20 UNDERTAKER Wendell Dippel & Son	ADDRESS 378 N

CAUSE OF DEATH in plain terms, so that it may be readily understood. Abbreviations and terms not in common use should not be employed. Any information which will assist in determining whether the disease was communicable, or whether it was due to conditions of occupation or to a dangerous trade, should be given. Any operation performed during the last illness should be stated. The statement of the duration of the disease is necessary. The statement of the place of death is necessary. The statement of the cause of death is necessary. The statement of the time of death is necessary. The statement of the place of burial is necessary. The statement of the undertaker is necessary. The statement of the address is necessary. The statement of the date of burial is necessary. The statement of the name of the deceased is necessary. The statement of the age is necessary. The statement of the sex is necessary. The statement of the color or race is necessary. The statement of the marital condition is necessary. The statement of the occupation is necessary. The statement of the birthplace is necessary. The statement of the parents is necessary. The statement of the informant is necessary. The statement of the registrar is necessary. The statement of the burial permit clerk is necessary. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51804 HEALTH DEPARTMENT—CITY OF BALTIMORE D51804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 15 18-091 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Brooks

(a) RESIDENCE. No. 1716 Prestbury St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Burner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Delia Carrol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed MAR 13 1921 ROBERT J. CRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to March 9, 1921, that I last saw her alive on March 9, 1921, and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH*, was as follows:

Erysipelas

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No special illness

(Signed) Zach. T. Morgan, M. D.

3-10-21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Mar. 12 1921
20 UNDERTAKER Edward Riggold	ADDRESS 1463 Canyst

TION is very important. See instructions on back of certificates.

D51805 HEALTH DEPARTMENT—CITY OF BALTIMORE D51805

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 906 N. Pine St.; 17 WARD) REGISTERED No. C 91

2-FULL NAME Carrie D. Brown

(Residence in Baltimore: No. 906 N. Pine St. St.; 1 yrs., 5 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, October 9, 1919 (Month) (Day) (Year)

7-AGE, 1 yrs. 5 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (Infant) None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto. Md,

PARENTS.

10-NAME OF FATHER, Joseph Brown

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md,

12-MAIDEN NAME OF MOTHER Carrie Calloway

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Carrie Brown

(Address) 906 N. Pine St.

15- Filed MAR 13 1921 ROBERT J. KRAUTER Registrar of Vital Statistics

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

March 11, 1921 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Lebanon

DATE OF BURIAL, March 13, 1921.

20-UNDERTAKER David Easton

ADDRESS 916 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Millie Garner

D51806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51806

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 Vine St. ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Millie Garner

(a) RESIDENCE. No. 834 Vine St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Paul Garner

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook 071

(b) General nature of industry, business, or establishment in which employed (or employer): Homework

(c) Name of employer: J. K. Hooper

9 BIRTHPLACE (city or town) (State or country): Howard Co

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Daniel Easton

(Address): 916 Pa ave

15 MAR 13 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1920, to March 11, 1921, that I last saw h[illegible] alive on March 9, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) Jas W. Hooper, M. D.

, 19 (Address) 346 E. 28th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	March 14 1921

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Pa ave

CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51807

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Edmondson Ave ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth L. Ketmate

(a) RESIDENCE. NO. 1011 Edmondson Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Frederick Ketmate

6 DATE OF BIRTH (month, day, and year) March 7 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Charles Gerwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant J. Frederick Ketmate. (Address) 1011 Edmondson Ave

15 MAR 13 1921 [redacted] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1920, to Mch 12, 1921, that I last saw h[illegible] alive on Mch 11, 1921, and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Chr. Bright's (Interstitial)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Edwin Murphy, M. D.

, 19 (Address) 1721 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Pauls. (Violettesville)	3-14 1921

20 UNDERTAKER Mrs. Chas A J Rohde ADDRESS N Arlington Ave

CAUSE OF DEATH. Physician must fill out back of certificates. See instructions on back TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51808 HEALTH DEPARTMENT—CITY OF BALTIMORE D51808

CERTIFICATE OF DEATH

1-PLACE OF DEATH St. Joseph's Hospital

REGISTERED No.....

CITY OF BALTIMORE: (No. ..... ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Boswell

(a) RESIDENCE. No. St Joseph Hosp ST., WARD. Kilmarnock Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Henry Boswell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant L. A. Barnett

(Address) 632 W. Arlington Ave

15 MAR 13 1921 [illegible] BRAUER Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1921, to Mar 12, 1921, that I last saw him alive on Mar 12, 1921, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. McElwain, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kilmarnock Va	March 12 1921
20 UNDERTAKER	ADDRESS
Chas. E. Branch	847 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D51809 HEALTH DEPARTMENT—CITY OF BALTIMORE D51809

E. CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 428 Twenty second St. 12th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph a. Hall.

(Residence in Baltimore: No. 428 Twenty Second 1/2 St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, Dec 24, 1868
(Month) (Day) (Year)

7-AGE. 52 yrs. 2 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): OK

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Jos. Hall

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jos. A. Hall

(Address) 428 Twenty Second 1/2 st.

MAR 13 1921 [illegible]
Filed ....., 191.... Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 8 1921, to March 10th 1921, that I saw h[illegible] alive on March 10th 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis and
Acute Bronchopneumonia

(Duration) 1 yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Nephritis

? (Duration) ? yrs. ? mos. ? ds.

(Signed) Geo. L. Wall M. D.

....., 191... (Address) 426 E. 22nd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	March 12 1921
20-UNDERTAKER	ADDRESS
George J. Ruth	735 Hanford Av.

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

951810

HEALTH DEPARTMENT—CITY OF BALTIMORE

951810

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 Ashland Ave. 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. W. Myers

(a) RESIDENCE. No. 2303 Ashland Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah J. Myers

6 DATE OF BIRTH (month, day, and year) Mar 17-46

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Chas. Henkel

(Address) 2303 Ashland ave

15 FILED MAR 13 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10-1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 10. 1921. to March 10. 1921.

that I last saw h~~im~~ alive on March 10. 1921.

and that death occurred, on the date stated above, at 11-25 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

Mitral Stenosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) Albert E. Singewald, M. D.

3/14, 1921 (Address) 1613 E. 20th Ste.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	3-14 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 51811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51811

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N. Montford ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward L. Gissel

(a) RESIDENCE. No. 811 N. Montford ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Bertha M. Gissel

6 DATE OF BIRTH (month, day, and year) July 21-77

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer H. Gamse + Bro

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Fred Gissel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Bertha M. Gissel (Address) 811 N. Montford ave

15 Filed MAR 13 1921 19 ALBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-11- 1921

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to March 11, 1921, that I last saw h[illegible] alive on March 10, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Walter W White

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Walter W White Jr, M. D.

3/12, 1921 (Address) 2800 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	3-14 1921
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans

CAUTION is very important. See instructions on back of certificates.

Form.—6-9-19—H. P. Co.—1000 Bks.

D51812

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51812

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. North Broadway ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Schmidt

(a) RESIDENCE. No. 804 N. Montford Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John Schmidt

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Walz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Schmidt (Address) 804 N. Montford

15 Filed MAR 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 12 1921

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to March 12, 1921, that I last saw her alive on March 12, 1921, and that death occurred, on the date stated above, at 2:05 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 5, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm Noble M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	March 15 1921

20 UNDERTAKER Burkert & Pickler ADDRESS 1739 Eager

Burial Permit Clerk

CAUSE OF DEATH. Please fill in all items. Use ditto marks (") where proper. Do not use "same" or "do." Be sure to answer every question. Where there is no physician, coroner must certify. See instructions on back of certificates. ATTENTION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestinal Obstruction

Spec.—6-9-19—H. P. Co.—1000 Bks.

9 51813

HEALTH DEPARTMENT—CITY OF BALTIMORE

9 51813

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 N Bradford ST.: 8 WARD) 79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Brader

(a) RESIDENCE. No. 1626 N. Bradford ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas J. Brader

6 DATE OF BIRTH (month, day, and year) May 3 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER August Stroot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Gumpman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Nicholas Brader

(Address) 1626 Bradford St

15 MAR 14 1921 [illegible] KRAUTER Registrar

Burial Permit Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1921

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1921, to March 10, 1921, that I last saw h~ alive on March 9, 1921, and that death occurred, on the date stated above, at 3 30 A.M. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Endocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward Mendelsohn, M. D.

. 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mar 14, 1921
20 UNDERTAKER	ADDRESS
Harry H Nitzke	Lombard & Gilmor

CAUSES OF [illegible] TION is very important. See instructions on back of certificates.

D 51814 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 15 WARD) 175-001 REGISTERED No. C

2-FULL NAME Thomas P. Mc Cormack

(Residence in Baltimore: No. 3042 Windsor Ave

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 8 yrs., 4 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, Oct 26, 1912
(Month) (Day) (Year)

7-AGE, 8 yrs. 4 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Thomas P. Mc Cormack

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Bridget Morkin

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. P. Mc Cormack

(Address) 3042 Windsor Ave

15- MAR 14 1921 [illegible] KRAUTER
Filed....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH March 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) found that said deceased came to his death on the day stated above. Inquest to be held March 14, 1921

The CAUSE OF DEATH* was as follows:

Fracture of base of skull (automobile accident) 3 hrs.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. H. Hennessey M. D.
(Coroner.)
March 13, 1921 (Address) 2242 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, March 14th, 1921

20-UNDERTAKER Martin Fatter for Sons — ADDRESS 1527 N. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D 51815 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3517 Greys Av St.; 26 Ward)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James W Barrett

(Residence in Baltimore: No. 3517 Greys Av St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 71 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boilermaker
(b) General nature of industry, business, or establishment in which employed (or employer): Shipyard

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James W Barrett

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rachael —

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace E Barrett

(Address) 3760 Lasseter Av

15- MAR 14 1921 [redacted] KRAUTER

Filed....., 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH March 12, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Pneumonia

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) Thomas Ryan M. D. (Coroner)

March 13, 1921 (Address) 1500 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral Balto | DATE OF BURIAL, 3-14-, 1921

20-UNDERTAKER J A Moran | ADDRESS 3000 E Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. State whether disease was contagious, if such was the case. Fill in all answers in full. Use black ink. Write plainly. Do not use abbreviations or ditto marks. Be particular and exact in every statement, as every item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51816 HEALTH DEPARTMENT—CITY OF BALTIMORE D51816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 91 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Douglas

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.

(Address) New City Hospital.

15 MAR 14 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1921 to March 10, 1921, that I last saw her alive on March 9, 1921, and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? No Microscopical Exam

(Signed) Jack R. Hogan M. D.

3/10/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 14 1921
20 UNDERTAKER	ADDRESS
L. Co. Brown & Son	108 W. Monty

TION is very important. See instructions on back of certificates.

D51817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51817

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 726 n Bond ST.; 6 WARD) REGISTERED No. C 6041

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucille Williams

(Residence in Baltimore: No. 726 n Bond St.; yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Single

6-DATE OF BIRTH, Mar 22 1920, 1920
March (Month) 22 (Day) (Year)

7-AGE, ... yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Samuel Williams

11-BIRTHPLACE OF FATHER (State or Country), S C

12-MAIDEN NAME OF MOTHER Mary Day

13-BIRTHPLACE OF MOTHER (State or Country), P A

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Williams
(Address) 618 Ensor St

15- MAR 14 1921 ....., 191.... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J. H. Wales M. D.
(Coroner)
3-13, 191... (Address) 4 E Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	March 14 1921
20-UNDERTAKER	ADDRESS
Mrs R A Elliott	1725 Ashland Ave

CAUSE OF DEATH to be filled in plain terms. Every item important. See instructions on back of certificate.

D51818 Derwart

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1-11 Josh Harpole St.; 9 WARD)

2-FULL NAME George A Derwart

(Residence in Baltimore: No. 1614 N Spring St.; yrs., mos. ds.)

REGISTERED No. C 75-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Boy

6-DATE OF BIRTH: October 6 1914
(Month) (Day) (Year)

7-AGE: 6 yrs. 5 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Andrew Derwart

11-BIRTHPLACE OF FATHER (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Teresa Kimlein

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Andrew Derwart

(Address) 1614 N. Spring St

15-MAR 14 1921 ROBERT J. KRAUSE

Filed ....., 191.... Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Shock

Delirium (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Smith M. D.
(Coroner)

3-17, 1921 (Address) 4 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, March 15, 1921

20-UNDERTAKER, Henry Hoeck Son — ADDRESS 1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question is important. See instructions on back of certificate.

D 51819

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 51819

CERTIFICATE OF DEATH

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 Melville Ave ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Emma Mister

(Residence in Baltimore: No. 625 Melville Ave St., 54 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1855 (Year)

7-AGE: 66 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer): 069

9-BIRTHPLACE (State or country): Talbot Co. Maryland

PARENTS

10-NAME OF FATHER: Severn Miller

11-BIRTHPLACE OF FATHER (State or country): Somerset Co. Md

12-MAIDEN NAME OF MOTHER: Bridget Daniels

13-BIRTHPLACE OF MOTHER (State or country): Somerset Co. Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Laura S. Wagner

(Address) 3601 Gurpus Oak Ave.

15- MAR 14 1921 [illegible] KRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 3, 1921 to, March 12 1921, that I saw her alive on March 2 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

..... (Duration) ..... yrs. ..... mos. 9 ds.

Contributory (SECONDARY) Dilatation of Heart

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed), E. J. Bouchelle M. D.

March 12, 1921 [Address] 2104 St. Paul St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemt DATE OF BURIAL: Mar 14 1921

20-UNDERTAKER: Bertram Cole ADDRESS: 1723 W. Lafayette Ave

State CAUSE OF DEATH in plain terms. DESCRIPTIVE TERMS ARE INSUFFICIENT. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D51820

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51820

CERTIFICATE OF DEATH.

1042

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2613 Bruce Ter ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lloyd L Evans

(Residence in Baltimore: No. 2613 Bruce Ter St.; ....yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Single

6-DATE OF BIRTH, Feb (Month) 24 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
1 yrs. mos. 20 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George B Evans

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Blanche A Ways

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo B Evans

(Address) 2613 Bruce Terrace

15-

Filed ..... 191.....

Registrar.

MAR 14 1921

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 6 1921, to March 13 1921, that I saw him alive on March 13 1921, and that death occurred, on the date stated above, at 8:50 A m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Fred B Jewett M. D.

March 14 1921. (Address) 2246 Penn Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto	Mar 15 1921

20-UNDERTAKER	ADDRESS
John J Fields	1300 N Broadway

Form — 6-9-19—H. P. Co.—1000 Blks.

D51821

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51821

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Vincent ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Dumpson

(a) RESIDENCE. NO. 1620 Vincent ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 19, 1905

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or min.
	15	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Dr Hoosey

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Dumpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ellicott City Md

12 MAIDEN NAME OF MOTHER Louisa Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Louisa Dumpson
(Address) 1620 Vincent St

15 Filed MAR 14 1921 ROBERT B. KRAUTZ Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1921, to Mar 10, 1921, that I last saw h[er] alive on Mar 10, 1921, and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. William Frey, M. D.

3/12, 1921 (Address) 1938 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar. 14 1921
20 UNDERTAKER	ADDRESS
James H Dennis	303 Presstman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Diseases of Women, Children, Accidents, Suicides, Homicides, etc., require special attention. Name of disease alone is insufficient. Indefinite terms, such as Debility, Old Age, Paralysis, Convulsions, Cancer, Tumor, Abscess, Fever, Inflammation, Hemorrhage, Ulceration, Consumption, Dropsy, Heart Disease, Kidney Disease, Liver Disease, Stomach Trouble, Bowel Trouble, Childbirth, Miscarriage, Premature Birth, Stillbirth, Blood Poisoning, Lockjaw, Meningitis, Pneumonia, Bronchitis, Pleurisy, Peritonitis, Appendicitis, Gastritis, Enteritis, Colitis, Hernia, Rupture, Intussusception, Obstruction, Gangrene, Septicemia, Uremia, Asphyxia, Anemia, Marasmus, Exhaustion, Shock, Coma, Congestion, Hypostasis, Embolism, Thrombosis, Aneurism, Valvular Disease, Arterial Sclerosis, Fatty Degeneration, Cyanosis, Jaundice, Hydrocephalus, Spina Bifida, Malformation, Monstrosity, Senility, Natural Causes, Unknown, Not Known, Not Ascertained, Not Certified, Not Diagnosed, Not Given, Not Stated, Not Known, Not Ascertained, Not Certified, Not Diagnosed, Not Given, Not Stated, are not sufficient. Name the disease causing death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 57822 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51822

CERTIFICATE OF DEATH.

28

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 909 N. Eutaw ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriett-Libby

(Residence in Baltimore: No. 909 N. Eutaw St.) (If not in Baltimore, give usual residence.) (If under 1 day, ..hrs. or ..min.) (If under 1 year, ..mos. ..ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, Feb (Month) 8 (Day), 1853 (Year)

7-AGE, 68 yrs. 1 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Allen

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Lloyd Libby

(Address) 909 N. Eutaw St.

15- Filed MAR 14 1921, 191.....

ROBERT B. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1914 ~~191~~, to March 11th 1921, that I saw h.. alive on March 9th 1921, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Resp.

..... (Duration) ..yrs. ..mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary

..... (Duration) ..yrs. ..mos. ..ds.

(Signed) ..... M. D.

3-11-, 1921. (Address) 924 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Aberdeen Bellis Co	March 14..., 1921
20-UNDERTAKER	**ADDRESS**
James F. Dennis	1303 Pennsylvania

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51823 HEALTH DEPARTMENT—CITY OF BALTIMORE D51823

CERTIFICATE OF DEATH.

10-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2918 E. Pratt ST.; 1 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta A. D. Feldmann

(a) RESIDENCE. NO. 2918 E. Pratt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a ~~Married~~, widowed, ~~or divorced~~
~~HUSBAND of~~
(or) WIFE of Christian Feldmann

6 DATE OF BIRTH (month, day, and year) March 22d-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Adam A. Trautner
(Address) 2918 E. Pratt St.

15 Filed MAR 14 1921 19 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1921, to Mar 11, 1921, that I last saw her alive on Mar 11, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B Tatlow, M. D.

3/18, 1921 (Address) 3 N. S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	March 14 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager St.

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51824 HEALTH DEPARTMENT—CITY OF BALTIMORE D51824

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Chepulis

(a) RESIDENCE. No. 637 Columbia Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(h) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Thomas Chepulis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Constant Matull

(Address) 418. N. Carrollton ave.

15 MAR 14 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 12, 1921, that I last saw him alive on March 12, 1921, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Infam. Arthritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bromshad M. D.

3-12 1921 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	March 14 21
20 UNDERTAKER	ADDRESS
John Grebliauskas	420 S. Pace

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

D51825 (Skilandis) HEALTH DEPARTMENT—CITY OF BALTIMORE 156 D51825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 815 Hollins ST. 18 WARD)

2-FULL NAME Joseph Skiladis or Skilandis

(Residence in Baltimore: No. 815 Hollins)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. (yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH, (Month) Dont Know (Day) , (Year) 1

7-AGE, 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Theodor Skilandis

11-BIRTHPLACE OF FATHER (State or Country): Lithuania

12-MAIDEN NAME OF MOTHER: Anna Burdulis

13-BIRTHPLACE OF MOTHER (State or Country): Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Paukauskas

(Address) 815 Hollins St.

15- FILED MAR 14 1921 19... FORST & KRAUTER Burial Permit Issued Register

CAUSE OF DEATH in plain terms, as that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) March (Day) 13, (Year) 1921

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.)

thereon and from the evidence obtained by said ~~(Inquest, au~~

~~topsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas inhalation

(Duration) yrs. a few hours

CONTRIBUTORY (Secondary) Suicide

(Duration) a few hours yrs. mos. ds.

(Signed) T K Jonas M. D. (Coroner.)

3-13, 1921 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, March 15, 1921

20-UNDERTAKER John Greblauckas — ADDRESS 425 S. Paca St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51826

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51826

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 951 Franklin Road ST. 16 WARD)

2-FULL NAME Catherine Williamson

(a) RESIDENCE. No. 951 Franklin Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. G. Williamson

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Lawrence Lacy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McConnick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Martin

(Address) 964 Franklin Road

15 Filed ....., 19.... Registrar

MAR 14 1921

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1921, to March 17 1921, that I last saw h.. alive on March 17 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Unknown. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3/13/21 (Address) 2707 Wilmot Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	March 19 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 100 B'k Lake St.

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. Do not use abbreviations or technical terms. Do not state mode of dying, such as heart failure, asphyxia, etc., but what disease caused such failure, asphyxia, etc. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 51827

1-PLACE OF DEATH

REGISTERED NO. 120

CITY OF BALTIMORE: (No. 2001 Hilton ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. McCubbin

(a) RESIDENCE. NO. 2001 Hilton ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D. McCubbin Sr.

6 DATE OF BIRTH (month, day, and year): Mar. 18, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: John Henry Hell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chestertown, Maryland

12 MAIDEN NAME OF MOTHER: Susan Ellen Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Oxford, Maryland

14 Informant: Mrs. Thomas A. Myers
(Address): 2001 Hilton Street

15 Filed ....., 19 .....

MAR 14 1921 Registrar

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 12th 1921

17 I HEREBY CERTIFY, That I attended deceased from October 6th, 1920, to March 12th, 1921, that I last saw her alive on March 12th, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis and Cirrhosis of Liver

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Cardiac Asthenia

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? no test

(Signed) Herbert E Sapp, M. D.

3/14 1921 (Address) 3080 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	3/14 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Dec.—6-9-19—H. P. Co.—1000 Bks.

D51828 HEALTH DEPARTMENT—CITY OF BALTIMORE D51828

CERTIFICATE OF DEATH. 110

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathew J. O'Connor

(a) RESIDENCE. NO. formerly 125 N Exeter St. ST.: Baltimore Md WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 0 mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	64	00	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md -

PARENTS

10 NAME OF FATHER John O'Connor

11 BIRTHPLACE OF FATHER (city or town) Co Roscommon (State or country) Ireland -

12 MAIDEN NAME OF MOTHER Mary A Murray

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat Balto Md

15 Filed MAR 14 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1890, 19, to March 12, 1921, that I last saw him alive on March 12, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis -

abt (duration) 0 yrs. 1/2 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia - Terminal -

abt (duration) 42 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

March 12, 1921 (Address) Mount Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	3/15 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Due to Constipation.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4404 Park Heights Ave. WARD) 46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam A. Nicoll

(a) RESIDENCE. No. 4404 Park Heights Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa W. Nicoll

6 DATE OF BIRTH (month, day, and year) Oct. 10 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna R. R.

9 BIRTHPLACE (city or town) (State or country) Lancaster Pa.

PARENTS

10 NAME OF FATHER Adam A Nicoll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Shaner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Pa

14 Informant Louisa W. Nicoll

(Address) 4404 Park Heights Ave

15 MAR 14 1921

ROBERT E KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1920, to Mch 12, 1921, that I last saw h.... alive on Mch 11, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid + Stomach

(duration) more than 2 yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stomach analysis. X-Ray Wall obstruction in both

(Signed) Geo. T. Kemp, M. D.

....., 19.. (Address) St. James Department.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Mch 15 1921

20 UNDERTAKER: Harry W. Ehlen — ADDRESS: 1944 W. Mount

IMPORTANT. See instructions on back of certificates.

D51830 HEALTH DEPARTMENT—CITY OF BALTIMORE D51830

Kamphaus

CERTIFICATE OF DEATH.

167

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital St.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia A. Kamphaus

(Residence in Baltimore: No. 802 N. Milton St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem'l

4-COLOR OR RACE, Wh'y.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wife

6-DATE OF BIRTH, Dec 17 (Month) (Day), 1918 (Year)

7-AGE, 3 yrs. 3 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Kamphaus

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Bertha Gerbgraps

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Kamphaus

(Address) 802 N. Milton Ave

15-

Filed MAR 14 1921 191.....

BOBERT S KRAUTER
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Mar.... (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns from Bedlinen

Coffee off Stove

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm H Neilley M. D. (Coroner.)

3-13. 1921 (Address) 4 E. Lex. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, March 14, 1921

20-UNDERTAKER Wm A. Hartley

ADDRESS 814 N. Washington St

N. B. EVERY BLANK must be filled with the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51831

CERTIFICATE OF DEATH.

+120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.; 25th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah D. Markland

(a) RESIDENCE. No. Reisterstown—Balto Co ST.; Md- WARD Reisterstown Baltimore

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married-

5a If married, widowed, or divorced (or) WIFE of Charles E. Markland

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Abt	69	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher 68

(b) General nature of industry, business, or establishment in which employed (or employer) School work-

(c) Name of employer Retired -

9 BIRTHPLACE (city or town) Not Given-
(State or country) Maryland-

PARENTS

10 NAME OF FATHER Benj Jackson

11 BIRTHPLACE OF FATHER (city or town) Not Given-
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Bowers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland-

14 Informant Record of Mt Hope Retreat
(Address) Mt Hope Balto Co. Md.

15 Filed MAR 14 1921 ROBERT S. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 7th 1920, to Mch 13 1921, that I last saw her alive on Mch 12 1921, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Syphilis-

Abt (duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia-Senile-

Abt (duration) yrs. 6 or 8 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hamstead Md.	Mch 14 1921
20 UNDERTAKER	ADDRESS
Wm J. Tickner & Sons	A. T. and

N. B.—WRITE PLAINLY. WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51832 HEALTH DEPARTMENT—CITY OF BALTIMORE D51832

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 W. Lexington St.; 16 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Foulkes.

(a) RESIDENCE. No. 1102 W. Lexington St.; ST., ... WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Foulkes

6 DATE OF BIRTH (month, day, and year): Mar 5 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Glasgow Scotland

12 MAIDEN NAME OF MOTHER: Elizabeth Kenney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Glasgow Scotland

14 Informant: Geo. F. Fiske (Address) 320 W. Lexington

15 Filed MAR 14 1921 Robert J. Krautel, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 9th, 1921, to Mar. 12th, 1921, that I last saw h[illegible] alive on Mar. 12th, 1921, and that death occurred, on the date stated above, at 8.35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Intestinal Obstruction

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No. Phys. Examination

What test confirmed diagnosis?

(Signed) Fred J. Bamfield, M. D.

(Address) Bal. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mch 14 1921
20 UNDERTAKER: Wm. J. Redmond Son	ADDRESS: Norther

CAUSE OF DEATH must be plainly stated, and all questions answered. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D57833 HEALTH DEPARTMENT—CITY OF BALTIMORE D57833

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1515 Bradford ST.; 8 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. W. H Baker

(a) RESIDENCE. NO. 1515 Bradford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 9 mos. ds. How long in U. S., if of foreign birth? 14 yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 4th 06

7 AGE: Years 14; Months 9; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Martin H Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Pemberton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs H Baker 1515 Bradford St

15 Filed MAR 14 1921 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1921, to Mar 11, 1921, that I last saw him alive on Mar 11, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical

(Signed) H H Shreve M. D.

19 (Address) 1220 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mary Redmen Cem — DATE OF BURIAL: Mar 15 1921

20 UNDERTAKER: Robt J Turner — ADDRESS: 1444 Pmay

CAUSE OF DEATH. Please fill in all items. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51834 HEALTH DEPARTMENT—CITY OF BALTIMORE D51834

CERTIFICATE OF DEATH.

+28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 38th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie McKenna

(a) RESIDENCE. No. 105 Adams St Wilmington Del ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married -

5a If married, widowed, or divorced (or) WIFE of: James McKenna

6 DATE OF BIRTH (month, day, and year): July 4-1887

7 AGE: Years 33 Months 8 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Wilmington Del -

PARENTS

10 NAME OF FATHER: Thomas Slattery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not given Maryland -

12 MAIDEN NAME OF MOTHER: Alice O'Leary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wilmington Del -

14 Informant: Records of Mt Hope Retreat (Address): Mt Hope Baltimore Md

15 Filed MAR 14 1921 ROBERT J KRAUSE Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 12th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 21 1917 to Mch 12th 1921, that I last saw h[illegible] alive on Mch 12th 1921, and that death occurred, on the date stated above, at 12.15 Noon.

The CAUSE OF DEATH* was as follows:

Pul- Tuberculosis -

abt

(duration) 4 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary): Chr Melancholia

abt (duration) 3 yrs. 1/2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Wilmington Del

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Mch 12 -. 1921 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilmington Delaware

DATE OF BURIAL: March 14 1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM J. MOWEN, Successor)

ADDRESS: 308 W NORTH AVE

CAUTION—Before burial or removal, this certificate must be filed with the Registrar of Vital Statistics. See instructions on back of certificates. IT IS VERY IMPORTANT.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51835 HEALTH DEPARTMENT—CITY OF BALTIMORE D51835

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S. Duncan ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard W. Smith

(a) RESIDENCE. NO. 317 S. Duncan ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): March 11th 1921

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Luther H. E. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Matilda Fiesler Mar 13 1921

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Luther H. E. Smith
(Address): 317 S. Duncan St.

15 Filed MAR 14 1921, 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to March 12, 1921, that I last saw him alive on March 12, 1921, and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Ø Six Months Gestation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. L. Valentine M. D.

(Address) 2 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: March 14th 1921

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 403 S. Wolfe St

TION is very important. See instructions on back of certificates.

D 51836

D 51836

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH Mercy Hosp. REGISTERED NO.....

CITY OF BALTIMORE: (No. 836 S Kenwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Casper Friese

(a) RESIDENCE. NO. 836 S Kenwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Mary Friese

6 DATE OF BIRTH (month, day, and year) April 29 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER C Friese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Foyel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John Friese 836 S Kenwood Ave

15 Filed MAR 14 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1921, to March 11 1921, that I last saw him alive on March 11 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Abscess Larynx & Empyema

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

Duration yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) W W Brysard, M. D.

, 19 (Address) 805 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Mar 16 1921
20 UNDERTAKER	ADDRESS
Stephen J Hackbrook	1005 Kenwood

CAUSE OF DEATH TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar Pneumonia

Spec.—8-24-14—M. & T.—2000 Bks.

D 51837 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 Cherry & Curtis Bay St.; [illegible] WARD)

REGISTERED NO. C [illegible]

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Anna Szymanski

(Residence in Baltimore: No. 16 Cherry & Curtis Bay St., 58 yrs., 2 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, January (Month) 6 (Day), 1863 (Year)

7-AGE, 58 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Thomas Zielinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Jadwiga Skopnicka

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Szymanski

(Address) Curtis Bay

15- MAR 14 1921 Filed....., 191.... ROBERT E KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 12 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1920, to Mar 12 1921, that I saw h[illegible] alive on Mar. 11 1921, and that death occurred, on the date stated above, at 1 30 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy & Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Bright's

(Duration) 2 yrs. mos. ds.

(Signed) [illegible] M. D.

Mar 12, 1921 (Address) 134 E. Patapsco

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death [illegible] yrs. [illegible] mos. [illegible] ds. In the State [illegible] yrs. [illegible] mos. [illegible] ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross DATE OF BURIAL, March 14, 1921

UNDERTAKER William Fallon ADDRESS 1118 E. [illegible]

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 51838

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51838

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1143 Haubert St.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry E Sommers Jr

(Residence in Baltimore: No. 1143 Haubert St.; 7 mo. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, July (Month) 10 (Day), 1920 (Year)

7-AGE, yrs. 8 mos. 3 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry E Sommers

11-BIRTHPLACE OF FATHER (State or Country), California

12-MAIDEN NAME OF MOTHER Mary Deffley

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Sommers

(Address) 1143 Haubert St.

15-

Filed MAR 14 1921 191 [redacted] KRAUTER

Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 12 1921, to Mar 13 1921, that I saw h alive on Mar 12 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Nasal Catarrh

last winter (Duration) yrs. mos. 1 ds.

(Signed) T. B. B. [illegible] M. D.

3/14/21, 191 (Address) 423 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. | DATE OF BURIAL, March 17 1921

20-UNDERTAKER Margaret G Flynn | ADDRESS 1422 Light St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1090 Bks.

D 57839 HEALTH DEPARTMENT—CITY OF BALTIMORE D 57839

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2807 Kennedy Ave. (WARD) 9

REGISTERED NO. 128

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie J Wilson

(a) RESIDENCE. No. 2807 Kennedy Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James S Wilson

6 DATE OF BIRTH (month, day, and year) Nov. 13/1874

7 AGE: Years 46; Months 3; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER George R Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Ellen A Clement

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant James S Wilson (Address) 2807 Kennedy Ave

15 Filed MAR 14 1921 [illegible] Registrar

Dr. R. S. Kirk 3126 Harford Ave.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1920, to Mch 12th, 1920, that I last saw h.. alive on Mch 12th, 1920, and that death occurred, on the date stated above, at 12:50 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Coma,

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 8/20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert S. Kirk, M. D.

, 19 (Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Mch 15 1921
20 UNDERTAKER	ADDRESS
J. W. Cook & Nathan	

TION is very important. See instructions on back of certificate.

D51840 HEALTH DEPARTMENT—CITY OF BALTIMORE 8D51840

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2655 Lehman ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Volandt

(Residence in Baltimore: No. 2655 Lehman St.; yrs., 37 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 20 (Day), 1883 (Year)

7-AGE, 37 yrs. 7 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Iron worker
(b) General nature of industry, business, or establishment in which employed (or employer): Structural

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Charles Volandt

11-BIRTHPLACE OF FATHER (State or Country). Balto. City

12-MAIDEN NAME OF MOTHER Lydia J. Wheeler

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. F Volandt

(Address) 3409 Freemont Ave

15- MAR 14 1921 [illegible] Filed ..... 191... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 12 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 4 hours yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H Fenton M. D. (Coroner.)

Mar 15, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, London Park — DATE OF BURIAL, 3/15, 1921

20-UNDERTAKER William Cork — ADDRESS 502 E Hoff

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D61841 HEALTH DEPARTMENT—CITY OF BALTIMORE D51841

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital (WARD) 7

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Palmer

(a) RESIDENCE. NO. 820 N Spring ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced (or) WIFE of Norman Palmer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER J Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs Lena Brown

(Address) 1624 Mc Elderly

15 Filed MAR 4 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13/ 1921

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to March 13, 1921, that I last saw her alive on March 12, 1921, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nut Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms + clinical findings

(Signed) Frank C Marino M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 3/15 1921

20 UNDERTAKER William Cook

ADDRESS 502 E Nord

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Forword.

D51842

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51842

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 736 E 36th St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Susan Forwood

(Residence in Baltimore: No. 736 E 36th St.; 76 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May 20, 1844
(Month) (Day) (Year)

7-AGE, 76 yrs. 7 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edmund Buel

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margarette Foy.

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C. Forwood

(Address) 42[illegible] E—25th

15-

Filed MAR 14 1921 191.... [illegible] KRAUTER

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13th, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11th 1921 to March 13th 1921, that I saw h[illegible] alive on March 11th 1921, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Colon Carcinoma

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

March 13 1921 (Address) 1401 E 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 3/15, 1921

20-UNDERTAKER William Cook

ADDRESS 502 6 North

Spec.—6-9-19—H. P. Co.—1000 Bks.

Deleted 64 Ok. Ave.

D51843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51843

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 E. 33rd St. ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence H. Murphy

(a) RESIDENCE. No. 715 E 33rd St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Gertrude Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Florence Martin

(Address) 715 E. 33rd St

15 Filed MAR 14 1921, 19.. Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to Mar. 13, 1921, that I last saw him alive on March 9, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Blewett, M. D.

Mar. 13/21, 19 (Address) 621 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Mch 16 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Fay

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

D 51844 ~~Baltimore~~ Pa

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51844

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Inf ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Boyden

(a) RESIDENCE. NO. 1807 Barkley ST., WARD. Lockraven Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Screen fixter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lockraven Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Laura Palmer

(Address) 1807 Barkley St

15 Filed MAR 14 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 23rd, 1921, to March 14, 1921, that I last saw h Mr alive on " " , 19 " , and that death occurred, on the date stated above, at 3. A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Lung

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. D. Noble, M. D.

. 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York NY	Mar 17 19
20 UNDERTAKER	ADDRESS
Wm Cook	22 Pitt

CAUSE OF DEATH to be filled in plainly, preferably with ink. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51845 HEALTH DEPARTMENT—CITY OF BALTIMORE qr D51845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Reason

(a) RESIDENCE. No. 1214 South Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Archie Reason

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Isaac Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Archie Reason
(Address) 1214 South Ave

15 Filed MAR 14 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar, 11- 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to March 11, 1921, that I last saw h-r alive on March 11, 1921, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 4 yrs. 4 mos. 8 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

with Pleural Pain (duration) 4 yrs. 4 mos. 8 ds.

18 Where was disease contracted if not at place of death? 1214 South Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Diagnosis

(Signed) Wm. L. Hall, M. D.

19 (Address) 1126 E. 23rd St. Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
North Gordon Edmondson Co	Mar, 14 1921
20 UNDERTAKER Samuel A Heusley	ADDRESS 578 N Gilmor

CAUSE OF DEATH. See instructions on back of certificate. IMPORTANT. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51846 HEALTH DEPARTMENT—CITY OF BALTIMORE D51846

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 24912

CITY OF BALTIMORE: (No. 1520 Bell ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zenetta S. Rowley

(a) RESIDENCE. NO. 1520 Bell ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

CAUSE OF DEATH to be plain terms, so that a non-medical person may understand it. Use no abbreviations or ditto marks. Statement of contributory cause of death is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W Rowley

6 DATE OF BIRTH (month, day, and year) - Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Steven Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Drummond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant - Charles Rowley
(Address) 1520 Bell St

15 [illegible] MAR 14 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 11, 1921, that I last saw h[illegible] alive on March 10, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) C Burwell M. D.

(Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Mar 15 1921

20 UNDERTAKER	ADDRESS
E J Fanning	1460 Cutting Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

D51847 HEALTH DEPARTMENT—CITY OF BALTIMORE D51847

CERTIFICATE OF DEATH.

REGISTERED No. 1578

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Garrison ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella C. J Becker

(a) RESIDENCE. No. 2500 Garrison ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 9 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Christiana Rasch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Christiana Becker
(Address) 2500 Garrison ave

15 MAR 14 1921 [redacted] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from July-16 1920 to Mar-13 1921, that I last saw h[illegible] alive on Mar-13 1921, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis (cause unknown), with pulmonary embolism

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Hartley Cole M. D.

3/18 1921 (Address) 2202 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~, CREMATION OR ~~REMOVAL~~	DATE OF BURIAL
London Park Cemetery	March 15 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51848 HEALTH DEPARTMENT—CITY OF BALTIMORE D51848

CERTIFICATE OF DEATH.

REGISTERED NO. 126

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Jacobs

(a) RESIDENCE. No. 604 Longwood ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	widowed

5a If married, widowed, or divorced HUSBAND of WIFE of Elizabeth Maynard Jacobs

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles H. Jacobs
(Address) 2944 Edmondson ave

15 MAR 14 1921 ROBERT J. KLAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 13 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-11- 1921, to 3-13 1921, that I last saw h[illegible] alive on 3-13 1921, and that death occurred, on the date stated above, at 8.10 A m.

The CAUSE OF DEATH* was as follows: Hypertrophied prostate with acute retention

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 3-13-21

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Lt. Vance Hooper, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 1921

20 UNDERTAKER Geo. Weber & Son ADDRESS 2808 Edmondson Av

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51849 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51849

CERTIFICATE OF DEATH.

2579

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 707 Roland Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maj. Morgan D. Lewis

(Residence in Baltimore: No. same as above St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 23, 1843
(Month) (Day) (Year)

7-AGE, 77 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hotel Manager
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Theodore Lewis

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Levantia Flint

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. D. Lewis

(Address) 707 Roland Ave Arlington Station Va

15- Filed MAR 14 1921, 191.. ROBERT B KRAUTH Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1918, to March 12th 1921, that I saw h-im alive on March 12th 1921, and that death occurred, on the date stated above, at 9 45 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Myo. & Endo. Carditis

(Duration) 10 yrs. abt mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis & Angina

(Duration) 9 yrs. mos. ds.

(Signed) Wm Benham R. Carter M. D.

Mar. 12th, 1921. (Address) Roland Park.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Arlington Station Va

19-PLACE OF BURIAL OR REMOVAL, Arlington Va DATE OF BURIAL, Mch. 15, 1921

20-UNDERTAKER John O Mitchell ADDRESS 120 W. Fayette St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51850 HEALTH DEPARTMENT—CITY OF BALTIMORE D51850

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH Baltimore City REGISTERED NO.....

CITY OF BALTIMORE: (No. 2006 Park Ave ST.: 13 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moore B. Garland

(a) RESIDENCE. No. 2006 Park Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Brent

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	7	5 ~~10~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm D. Garland.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maria McKinney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Moore B. Garland (Address) 2006 Park Ave Md Wash.

15 MAR 14 1921 Registrar

Burial Permit Issued

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6. 1921, to March 12, 1921, that I last saw him alive on March 12, 1921, and that death occurred, on the date stated above, at 7 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~Ex~~ Examination ~~of~~ post mortem

(Signed) W. F. Ingram, M. D.

19 (Address) 439 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forrane Cemetery	Mch 14 1921
20 UNDERTAKER	ADDRESS
John Mitchell	1201 N. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

Saffield

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51851 — D51851

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 Riversidedrive ST.: 24 WARD) 79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rebecca Saffield

(a) RESIDENCE. No. 1419 Riversidedrive ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of James N. Saffield

6 DATE OF BIRTH (month, day, and year) Dec 11 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Wm H Sevier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Rebecca Beard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md

14 Informant Joseph Sevier
(Address) 1419 Riverside Dr.

15 Filed MAR 14 1921 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH. IMPORTANT. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Mar 12 1921, that I last saw h[er] alive on Mar 11 1921, and that death occurred, on the date stated above, at 3.20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm Sutphen, M. D.

3/12 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	3/14/21
20 UNDERTAKER	ADDRESS
John T Tabb & Sons	1318 Light

Spec.—6-9-19—H. P. Co.—1000 Blks.

46690

HEALTH DEPARTMENT—CITY OF BALTIMORE

051852

CERTIFICATE OF DEATH.

051852

REGISTERED NO. 132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lidonia Brale

(a) RESIDENCE. No. 527 Robert St. Balto ST. Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Isaac Brale

6 DATE OF BIRTH (month, day, and year) Nov 24-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Carrol.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Jason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) J H Hospital Records

15 MAR 14 1921 [redacted] KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6- , 1921, to March 11 , 1921, that I last saw he alive on March 11- , 1921, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

General Peritonitis —

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Pyosalpinx, Bilateral —

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 7. 1920

Was there an autopsy? Yes.

What test confirmed diagnosis? Yes. —

(Signed) L P Wharton, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Star Cem Catonsville	Mar 14 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

CAUSE OF DEATH ... back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

97-010 D51853

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 N. Broadway ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosina C. Summers

(a) RESIDENCE. NO. 925 N. Broadway ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of George D. Summers deceased

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ppo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John J. Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Jenter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Sophia Olgart,
(Address) 1315 N. Central Ave.

15 Filed MAR 14 1921 ROBERT P. KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Act 1, 19 21, to Mch 12, 19 21,
that I last saw h alive on March 12, 19 21,
and that death occurred, on the date stated above, at 1P m.
The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Julius Friedenwald, M. D.

Mch 14 1921 (Address) 1013 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Mch, 15, 1921
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway,

CAUTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 51854

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 704 Harford Ave ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Moulden

(a) RESIDENCE. No. 705 S. Parrish ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred One yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Cornelia Moulden

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Moulden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles Moulden

(Address) 205 S Parrish St

15 Filed MAR 14 1921 ROBERT B. KRAUTH Registrar

Burial Permit Issued

CAUSE OF DEATH—INFORMATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17

I HEREBY CERTIFY, That I attended deceased from March 4. 1921. to March 11. 1921. that I last saw him alive on March 11. 1921. and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

3/14 1921 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Cem March 14th 1921

20 UNDERTAKER — ADDRESS

A. Jones 207 S Stricker

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51855

CERTIFICATE OF DEATH.

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1346 Stricker ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Yeager

(a) RESIDENCE. No. 1346 Stricker St ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of married

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Edward Henderson
(Address) 1346 Stricker St

15 FILED MAR 14 1921 [illegible] A. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11-1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30 - 1921, to March 11, 1921, that I last saw her alive on March 10, 1921, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Nervous Breakdown & Bright Complication Disease
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Nervous Breakdown & Complication Disease (duration) yrs. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. W. Kennard, M. D.
3-12 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Mar 14 1921
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 Carey

CAUSE OF DEATH. This line should be filled out by the attending physician, if possible. If not, the coroner should be notified at once. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51886

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51886

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 2792 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Dawson

(a) RESIDENCE. No. Pimlico Rd & Manhattan Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1yr 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wellington B. Dawson

6 DATE OF BIRTH (month, day and year): Nov. 21-1862

7 AGE: Years 58 yrs; Months 3; Days 17; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Falls Wm

PARENTS

10 NAME OF FATHER: Henry Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Mary R. Harryman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs Virginia Dawson

(Address) Pimlico Rd & Manhattan Ave

15 MAR 14 1921 [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-10 1921

17

I HEREBY CERTIFY, That I attended deceased from 3-3, 1921, to 3-10, 1921,

that I last saw h[illegible] alive on 3-10, 1921,

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Endarteritis obliterans with gangrene

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia + tonsilitis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-3-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. McK Craig, M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Mch 14 1921

20 UNDERTAKER: H. E. Hughes — ADDRESS: 424 N. Broadway

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

14642 D 51857 — CERTIFICATE OF DEATH. — D 51857 X45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James S. Hancock.

(a) RESIDENCE. NO. 54 Metcalf St Newbern N.C. ST.: WARD Barbour Rd

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Unknown 21 How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Brittanna J. Hancock.

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	5	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 0 1 5

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Wm. B. Hancock.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Brittanna Chadwick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAR 14 1921 ROBERT A ABAUTEN Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22 1921, to March 13 1921, that I last saw him alive on March 13 1921, and that death occurred, on the date stated above, at 4 35 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/8/21

Was there an autopsy? ...

What test confirmed diagnosis?

(Signed) H H Hailey. M. D.

3-15-1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newbern, N. C. — DATE OF BURIAL: Mch 14 '21

20 UNDERTAKER: H E Hughes — ADDRESS: 424 Broadway

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

~~251858~~ HEALTH DEPARTMENT—CITY OF BALTIMORE ~~251858~~ 5051858

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 E. Eager ST.: 76 WARD)

2-FULL NAME Mary Frances Alberger

(a) RESIDENCE. NO. Baltimore Co ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Alberger

6 DATE OF BIRTH (month, day, and year): May 15 1864

7 AGE — Years: 56 Months: 9 Days: 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Bernard Noe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Rush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Alberger (Address) Catonsville Md

15 MAR 14 1921 ROBERT J. KRAFFT Registrar of Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 8, 1921, to Mar 12, 1921, that I last saw her alive on Mar 11, 1921, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustive Psychosis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. G. Ruhe, M. D.

(Address) Chas & Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Mar 15 1921

20 UNDERTAKER: J Deering & Co — ADDRESS: 2005 Eager

CAUSE OF DEATH. See instructions on back of certificates. ATION is very important.

March 18th 1921 (See affidavit over) Geo H Gere

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51859 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51859

CERTIFICATE OF DEATH. 61-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. New City Hospital ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Carl Norgaard~~ Karl Johannes Norgaard

(a) RESIDENCE. No. Unknown ~~Hospital~~ (Hilfsbaas) ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. 1 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	~~20~~ 18/17	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Sweden~~ Denmark

PARENTS

10 NAME OF FATHER Adroka Norgaard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark ~~Sweden~~

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark ~~Sweden~~

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed MAR 14 1921, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921 to March 13, 1921

that I last saw him alive on March 12, 1921

and that death occurred, on the date stated above, at 4:15 A.m.

The CAUSE OF DEATH* was as follows:

Epidimic Meningitis

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Finding Meningococcus

(Signed) Zach. R. Morgan M. D.

3/14/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Mar. 16 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N Bdlo St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Baltimore, Md., March 18, 19

I do hereby make oath that the following statements given on Baltimore City Health Department Death Certificate No. D-51859, are not correct; also to the following corrections.

	Given on Certificate.	Correct Statem
Residence	S. S. Hippolas	S. S. Hippalos.
Full Name	Carl Norgaard	Karl Johannes Norgaar
Date of Birth.	1903.	Sept. 29, 1903
Age	18 years.	17 years, 5 mos., 15
Birthplace	Sweden	Denmark.
Birthplace of Father	Sweden	Denmark.
Birthplace of Mother	Sweden	Denmark.

Zach. T. Norgaan

Physician.

Subscribed and sworn to before me this 18th day of March, 19

Ruth Gaither

Notary Publ

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51860 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51860

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH REGISTERED NO.....

CITY OF BALTIMORE: (No. 712 Newington Ave. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Paul

(a) RESIDENCE. NO. 712 Newington Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Chas. Paul

6 DATE OF BIRTH (month, day, and year) Apr. 6, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Sandler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Agnes Foester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Paul

(Address) 712 Newington Ave.

15 Filed MAR 14 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to March 13, 1921, that I last saw h. alive on March 17, 1921, and that death occurred, on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Aortic Insufficiency

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Elmer B Freeman, M. D.

19 (Address) 412 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Mar. 15 1921
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1411 Light St.

D.51861 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51861

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 11 W. West St. St.) 24 79 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Miller.

(Residence in Baltimore: No. 618 E. Clement St. St.; 31 yrs., 0 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male.	White.	Single

6-DATE OF BIRTH, March 9th. 1890, 1
(Month) (Day) (Year)

7-AGE, 31 yrs. 0 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver.
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William Miller.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Eliza Fox.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wenger. (sister)

(Address) 618 E. Clement St.

15- Robert E. Harrison,
(Date) ....., 191....
Burial Permit Clerk. Registrar.

MAR 14 1921

CAUSE OF DEATH in plain terms, as that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Otto K. Reinhardt M. D.
(Coroner.)

March 14 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem.	Mar. 13 1921
20-UNDERTAKER	ADDRESS
Margaret J. Flynn	1422 Eight St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51862 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51862

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 N Eutaw St. 11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Bruce Bowie

(a) RESIDENCE. No. 805 N. Eutaw St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Clara Bowie

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer (2nd Civil)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co. Md

PARENTS

10 NAME OF FATHER Thos. F. Bowie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs M. C. Bowie (Address) 805 N. Eutaw St.

15 Filed ... 19... Robert P. Harrison, Registrar

AR 14 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1921, to March 12, 1921, that I last saw him alive on March 12, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Focomotor Ataxia

(duration) Several yrs. over 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Loss of all reflexes + and Wassermann Negative

(Signed) Hunter Pinkerton, M. D.

March 14, 1921 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	March 14 1921
20 UNDERTAKER	ADDRESS
A. J. Eastern & Son Co	Eastern Ave & Ellwood

CAUSES OF DEATH MUST BE STATED PLAINLY. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51863 HEALTH DEPARTMENT—CITY OF BALTIMORE D51863

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N. Rose ST.: 6 WARD)

2-FULL NAME. Wenceslaus Novotny

(a) RESIDENCE. NO. 424 N. Rose ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Novotny

6 DATE OF BIRTH (month, day, and year) Unknown 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Novotny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mary Bull

(Address) 424 N. Rose St

15 Filed ... 19 Robert P. Harris Registrar

MAR 14 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Mar 13 1921, that I last saw h. live on March 12 1921 and that death occurred, on the date stated above, at 9:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Mitral Regurgitation
Chronic Nephritis
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lung
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Ruzicka M. D.

3-13-21 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mar 16 1921
20 UNDERTAKER	ADDRESS
Ernest Brockstar	1906 Eastlake

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2.51864 2.51864

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2909 Garrison Ave (or) ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Heliana L. Beazley

(a) RESIDENCE. No. 2909 Garrison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Beazley

6 DATE OF BIRTH (month, day, and year): June 10 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Thomas Beazley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Clira Beazley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs E M Whaley

(Address): 2909 Garrison

15 Filed: AR 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-12-1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1921, to Mar 12 1921, that I last saw him alive on 3-12-, 1921, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm A. Duvall, M. D.

, 19 (Address) 3523 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	3/15 1921
20 UNDERTAKER: William Cook	ADDRESS: 502 E North Ave

CAUTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51865 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51865

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S Stricker ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Donahue

(a) RESIDENCE. No. 316 S. Stricker St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sabina Donahue

6 DATE OF BIRTH (month, day, and year) Mar. 17. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Messenger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gas Co. 080

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Luke Donahue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marg. Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs P. Donahue

(Address) 316 Stricker

15 Filed MAR 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 13, 19.., to March 11, 1921,

that I last saw h.. alive on March 10, 1921,

and that death occurred, on the date stated above, at 6.20 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? U Date of —

Was there an autopsy? U

What test confirmed diagnosis? Physical

(Signed) Edward Nicholson, M. D.

, 19 (Address) 24 W Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	3/15 1921
20 UNDERTAKER	ADDRESS
George A Farley	Fulton & Fayette

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51866

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2342 Eutaw Place ST.: 13 WARD) REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Frankenthal

(a) RESIDENCE. NO. 2342 Eutaw Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Frankenthal

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gabriel Herzinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. M. Gans (Address) 2342 Eutaw Pl

15 Jan 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1921

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to January 13, 1921, that I last saw h[illegible] alive on March 13, 1921, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E W Read, M. D.

, 19 (Address) 190 Mendenhall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shaloam	1/15 1921
20 UNDERTAKER	ADDRESS
Harry Goodheim	1811 W Fayette

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.51867

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51867

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 N. Caroline St. ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Konig.

(a) RESIDENCE. No. 1726 N. Caroline St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry D. Konig.

6 DATE OF BIRTH (month, day, and year) Jan. 14 - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Landwehr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry D. Konig,

(Address) 1726 N. Caroline St.

15 Filed Robert P. Harrison Registrar

1 4 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1921, to March 12, 1921, that I last saw her alive on March 12, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia & Convulsions

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Loss of use of left arm & leg Convulsions

(Signed) R. J. Carman, M. D.

3-13, 1921 (Address) 1707 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery.	3/15 1921

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Mt. Royal Ave.

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 lbs.

D.51868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51868

CERTIFICATE OF DEATH.

REGISTERED NO. C 3077

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for the Aged of the H. & Church St.; Ward.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary King.

(Residence in Baltimore: No. Fulton Ave and Monroe St.; ..... yrs., Life mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White	Single

6-DATE OF BIRTH, January (Month) 15 (Day), 1861 (Year)

7-AGE, 60 yrs. 2 mos. ∘ ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Gerard Franklin King.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Eliza Findly

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Etta Cuddy

(Address) 400 N. Fulton Ave

15-

Filed ..... Robert P. Harrison, Registrar.

MAR 14 1921 Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 14. (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1921, to Mch 14 1921, that I saw h-er alive on Mch 9 1921, and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis Chronic

(Duration) 1 yrs. ∘ mos. ∘ ds.

CONTRIBUTORY (Secondary) Pericarditis

(Duration) ∘ yrs. 6 mos. ∘ ds.

(Signed) George E. Shannon M. D.

3/14, 1921 (Address) 700 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mount Olivet Cem	Mar 16, 1921.
20-UNDERTAKER	ADDRESS
Geo. J. Smith	1000 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51869

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Van Lill ST.; 1st WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Kelley

(Residence in Baltimore: No. 701 Van Lill St. 86 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, Unknown (Month), ... (Day), 1835 (Year)

7-AGE, 86 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Kelley

(Address) 3134 Elliott St.

15- Filed ..... 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MAR 14 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 10 191..., to Mar. 13 191..., that I saw h[illegible] alive on Mar. 13 191..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Val. Disease of .....
..... His Heart .....
.....
..... (Duration) Some yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Coney Island Hospital
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. McKee M. D.

Mar. 14, 1921. (Address) 6 N. Pine

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Tem. DATE OF BURIAL, Mar. 15..., 1921.

20-UNDERTAKER Peter Nicolaus ADDRESS 2046 Easter

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51870 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D. 51870

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 York Rd ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J Buchanan

(a) RESIDENCE. No. 1628 York Rd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Buchanan

6 DATE OF BIRTH (month, day, and year) Nov 11-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 023

(b) General nature of industry, business, or establishment in which employed (or employer) N Elizabeth

(c) Name of employer Home Butcher

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Buchanan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Dwyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs Mary Buchanan 1628 York Road

15 Filed MAR 14 1921 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1921

17 I HEREBY CERTIFY, That I attended deceased from July 20 1920 to Mar 15 1921, that I last saw h alive on Mar 15 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis

Atrophic

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Chas F. Carter M. D.

3/14 1921 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Mar 16 1921
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E Eager

CAUSE OF DEATH in plain terms. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.51871 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.51871

CERTIFICATE OF DEATH. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 2800 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert A. Trunell

(a) RESIDENCE. No. Washington D.C. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Trunell -

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	73	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Atty at Law - 042

(b) General nature of industry, business, or establishment in which employed (or employer) Law business -

(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington (State or country) N. C. -

PARENTS

10 NAME OF FATHER Charles N Trunell

11 BIRTHPLACE OF FATHER (city or town) Tunnelsburg (State or country) Md -

12 MAIDEN NAME OF MOTHER Catherine Hargis -

13 BIRTHPLACE OF MOTHER (city or town) Hillsboro (State or country) N. C -

14 Informant Records of Mt Hope Retreat (Address) Mr Robert F. Harrison,

15 Filed MAR 14 1921, 19 Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH Mch 13th 1921

16 DATE OF DEATH (month, day, and year) Mch 13- 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 28th, 1911, to Mch 13th, 1921, that I last saw h(e/s) alive on Mch 13th, 1921, and that death occurred, on the date stated above, at abt 11 P- m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Suddenly) following Chronic Gen. Arteritis of abt 10 Years duration -

abt (duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Hemorrhoids Cir & Chr. Gen Arteritis. abt (duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Washington D.C. -

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Mch 14th, 1921 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Glen - Md — DATE OF BURIAL Mar 14/ 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D.51872

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Burroughs

(a) RESIDENCE. NO. Aiken Md - ST. 28 WARD (Aiken-Cecil Co. Md)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred abt 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 49 yrs. — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	49	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Aiken Md -

PARENTS

10 NAME OF FATHER Mary F. Burroughs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Louisa Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gettysburg Pa -

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat

15 Filed MAR 14 1921, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 14- 1921

17 I HEREBY CERTIFY, That I attended deceased from ~~Feb 28th 1920~~, to Mch 14th, 1921, that I last saw h Er alive on Mch 12th, 1921, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Fibro Cystic Tumor of Uterus -

abt 8 or (duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr Delusional Mania

abt (duration) 21 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? [redacted] Aiken Md

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? ———

(Signed) Frank J Flannery, M. D.

Mch 14, 1921 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aiken - Cecil Co. Md — DATE OF BURIAL: Mar 15 1921.

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS: 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

Spec.—6-3-19—H. P. Co.—1000 Bks.

D. 51873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51873

CERTIFICATE OF DEATH.

452

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1318 Eutaw Place ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Hawthorne Gardner

(a) RESIDENCE. No. 1318 Eutaw Place ST., 11 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 55 yrs. 8 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~(or) HUSBAND of~~
(or) WIFE of Harry Gardner

6 DATE OF BIRTH (month, day, and year) June 29. 1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) New Port
(State or country) Connecticut

PARENTS

10 NAME OF FATHER ?-Hawthorne

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country) " "

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mr. Harry Gardner (Husband)
(Address) 1318 Eutaw Place

15 Filed MAR 14 1921, 19.. Robert P. Harrison, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1. —, 19 21, to Mar. 13, 19 21,
that I last saw h.. alive on Mar. 13, 19 21,
and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bilateral
Bronchial

(duration) .. yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Thoracic Glands

(duration) .. yrs. .. mos. .. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical finding

(Signed) Edwin A. Johnson M. D.

. 19 (Address) 1 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL March 15 19 21

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH must be plainly written. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51874 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51874

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Reservoir ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jedd W. Jarvis (Jarvis)

(a) RESIDENCE. No. 704 Reservoir ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 9 mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Oliver Jarvis

6 DATE OF BIRTH (month, day, and year) June 13 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer G. Fred Sworm Baltimore Maryland

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Simeon Mayo Jarvis

11 BIRTHPLACE OF FATHER (city or town) Boston (State or country) Mass

12 MAIDEN NAME OF MOTHER Sophia Thompson

13 BIRTHPLACE OF MOTHER (city or town) Harford Co (State or country) Maryland

14 Informant Bessie Oliver Jarvis (Address) 704 Reservoir st

15 Filed MAR 14 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1 1921, to Mar 13 1921, that I last saw h alive on Mar 1 1921, and that death occurred, on the date stated above, at 12 40 a. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) John W. Sanderson, M. D.

, 19 (Address) 1714 N. Carlin st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 16 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. north ave

CAUSE OF DEATH ON BACK OF CERTIFICATE. ATTENTION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other factory

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51875

28

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal T. B. Hospital ward 18)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Clarke.

(a) RESIDENCE. No. 415 Gilbert st. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	married

5a If married, widowed, or divorced (or) WIFE of Wellton Clarke.

6 DATE OF BIRTH (month, day, and year) dontknow 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER John Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Harriett Pawson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Records. M. J. H. (Address) Baltimore.

15 Filed MAR 14 1921 Robert P Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1921, to Mar 13, 1921, that I last saw h.e.r. alive on Mar 13, 1921, and that death occurred, on the date stated above, at 1.30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? X-Ray & Sputum.

(Signed) C. A. Falconbridge, M. D.

, 19 (Address) Baltimore. M.J.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Mar 16th 1921
20 UNDERTAKER Felix B Pope.	ADDRESS 102 E Madison

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

(Lucy M. Doyle)

D.S 1876

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D.51876

CERTIFICATE OF DEATH.

X45

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2124 Calvert St. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy M Doyle

(Residence in Baltimore: No. 2124 Calvert Street St.: 0 yrs., 0 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, January (Month) 30 (Day), 1850 (Year)

7-AGE, 71 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), W. Va

PARENTS.

10-NAME OF FATHER, Chapman H. Maupin

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Matilda Hope

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hoover

(Address) 212 Calvert St.

15-

Filed ....., 191.....

Registrar.

APR 7 1921

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it can be understood. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 10 1921, to March 14 1921, that I saw h.. alive on March 12 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Pancreas

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Robert Summers M. D.

3-14, 1921 (Address) 1418 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 14 ds. In the State ....yrs. ....mos. 14 ds.

Where was disease contracted, if not at place of death? Huntington W. Va

Former or usual residence Huntington W. Va.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Huntington W. Va	March 15, 1921.

20-UNDERTAKER	ADDRESS
P E Hughes.	424 W. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51877 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51877

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roberta Wilkinson

(a) RESIDENCE. No. 410 Washington St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 1919

7 AGE: 1 Years 6 Months 26 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. nd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Wilkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margt. Slagle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Grand

15 Filed MAR 14 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14 1921, to March 14, 1921, that I last saw her alive on March 14, 1921, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Tetany

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Electrical Reactions

(Signed) W C Davison, M. D.

, 19 (Address) 4 W. Lt. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: 3/17 192

20 UNDERTAKER: I. Few McCully — ADDRESS: 130 E. Fay

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51878

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51878

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Weaver

(a) RESIDENCE. NO. 1117 N. Cary ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy Weaver

6 DATE OF BIRTH (month, day, and year) January 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa

PARENTS

10 NAME OF FATHER W. Weaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Antrim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Antrim

14 Informant Jos Weaver

(Address) 1426 McCulloh St

15 MAR 15 1921 Burial Permit Issued

CAUSE OF DEATH in plain terms. Indefinite answers, such as "Fever," "Debility," "Heart Disease," "Old Age," "Consumption of Bowels," "Cancer," "Tumor," "Abscess," "Child-birth," "Accident," "Fracture," "Injury," will not be accepted. Name the disease causing death, or, if from violent cause, state how injury was received. Write plainly. Do not use abbreviations. Do not copy from other certificates. TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to March 12, 1921, that I last saw him alive on March 12, 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

15 hr. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

(Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL March 15 1921

20 UNDERTAKER John H. Toadvine

ADDRESS 142 Ostend St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51879

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Hunter St. ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victorine Webster

(a) RESIDENCE. No. 2311 Hunter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Webster

6 DATE OF BIRTH (month, day, and year) [illegible] 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) Saunders

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Richard Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Francie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Webster
(Address) 2311 Hunter St

15 Filed MAR 15 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 1921, to Mar. 12, 1921, that I last saw h[illegible] alive on Mar. 12, 1921, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. L. Johnson, M. D.

, 19 (Address) 211 E. 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mar 15 1921
20 UNDERTAKER John H. Boadman	ADDRESS 1[illegible] W[illegible] St

CAUSE OF DEATH to be filled in plain terms, so that it can be understood by a layman. Do not use abbreviations or technical terms. Carefully read the questions and answer them in full. Your certificate is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

951880

HEALTH DEPARTMENT—CITY OF BALTIMORE

951880

CERTIFICATE OF DEATH.

REGISTERED No. C 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2927 Huntingdon Ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Frederick Altdorf

(Residence in Baltimore: No. 2927 Huntingdon Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 13 (9:30 P.M.) 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 7 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Michael Altdorf

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Frida Wagner

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Altdorf

(Address) 2927 Huntingdon Ave

15- Filed MAR 15 1921, 191.... MORRIS I KRAUTER Burial permit. Clerk. Registrar.

CAUSE OF DEATH in plain terms. If unknown, say so. Omit words "Cause unknown" unless important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 13 1921, to March 14 1921, that I saw h[illegible] alive on March 13 1921, and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Compression
Skull fracture
Coma (Duration) ..... yrs. 7 hrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Norment M. D.

3.14..., 1921. (Address) 334 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, March 15 1921

20-UNDERTAKER Chenowith Son — ADDRESS 3617 Eastern Ave

Teofila Milwicz

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51881

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 S Ann St ST.; V WARD)

2-FULL NAME Teofila Milwicz

(a) RESIDENCE. NO. 234 S Ann St ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 32 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Milwicz

6 DATE OF BIRTH (month, day, and year) March 10 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER George Stankiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Michalina Wisbrun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wladyslaw Milwicz (Address) 234 S Ann St

15 FILED MAR 15 1921 ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1 — 1921, to March 14, 1921, that I last saw her alive on March 12, 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral - Hemiplegia - Hemorrhage

(duration) yrs. 1/2 mos. ... ds.

CONTRIBUTORY (Secondary) Coma -

(duration) yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Mrs A Brauer, M. D.

19 (Address) 125 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	16 March 1921
20 UNDERTAKER	ADDRESS
John Weber 1803	Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact particulars of residence and occupation are very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Hartlik

D 51882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51882

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 S Bond ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Hartlik

(a) RESIDENCE. NO. 624 S Bond ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Tony Hartlik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rose Ruszcz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Rose Hartlik
(Address) 624 S Bond

15 MAR 15 1921 [illegible] LAUTER
Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/8, 1921, to 3/13, 1921, that I last saw him alive on 3/13, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Hem fractures & collapse

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms

(Signed) Jay A Phillips M. D.

3/14 1921 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 15 1921
20 UNDERTAKER	ADDRESS
John G Weber	1803 Bank

CAUSE OF DEATH in plain terms, so that a person not a physician may understand it. Do not use abbreviations or technical terms. Consult the Physician if necessary. Your certificate should show the cause of death which you would write on your own death certificate. Your certificate is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51883 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51883

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Melrose Ave ST.; 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margie Knost

(a) RESIDENCE. No. 703 Melrose Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 6 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Geo Knost

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Lena Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant George Knost
(Address) 703 Melrose alley

15 MAR 15 1921 ROBERT J. KRAUTH Registrar
Burial Permit 61089

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/10, 1921, to 3/13, 1921, that I last saw her alive on 3/12, 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E Sefuk, M. D.

, 19 (Address) 910 Leghs St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Mch 16 1921
20 UNDERTAKER	ADDRESS
C. L. Broad & Son	106 W Monte

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Do not use abbreviations or technical terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-51884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-51884

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 N Kenwood Ave ST.: 7 WARD)

2-FULL NAME Marie C. Reahle

(a) RESIDENCE. NO. 816 N. Kenwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Wm J Reahle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Catherine Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Catherine Reahle

(Address) 816 N Kenwood Ave

15 Filed MAR 15 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1920, to Mar. 13, 1921, that I last saw her alive on Mar. 12, 1921, and that death occurred, on the date stated above, at 8½ a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B. J. Hayden, M. D.

3/14. 1921 (Address) 1216 N. Carlin at

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Mar 16 1921
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son,	811 N Wolfe

Funeral Directors & Embalmers.

CAUSE OF DEATH to be filled in by physician. Name of disease causing death must be stated. If death was due to external causes (violence) state the nature of injury, and whether accidental, suicidal or homicidal. Where there was a contributory cause, it should be stated. Information is required for the benefit of the living. This certificate should be made out as completely and accurately as possible. Omission or inaccuracy of information will cause unnecessary correspondence and delay. Please write plainly with pen and ink. Do not use pencil. Do not fail to answer every question. If there is no person in attendance at the death, or if the person in attendance refuses to sign the certificate, it may be signed by the undertaker. See instructions on back of certificates.

Form.—6-9-19—H. P. Co.—1000 Bks.

D51885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51885

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Wyndside Gaston Ave (ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolphe Peterson

(a) RESIDENCE. NO. Wyndside Gaston Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) March 10, 21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5 days.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Peterson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penn.

12 MAIDEN NAME OF MOTHER Rose George

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Supt Peterson Home
(Address) Wyndside Gaston Ave

15 Filed MAR 15 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 15, 1921, that I last saw h.. alive on March 15, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clarence P. Egbert Brack M. D.

, 19 (Address) 1402 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3/15 1921

20 UNDERTAKER J. J. Stahl & Son ADDRESS 138 Eutaw St

CAUSE OF DEATH to be written in plain terms. See that all questions on back of certificates are answered. ATTENTION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51886 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51886

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 521 N. Decker Ave ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Schmidt

(a) RESIDENCE. NO. 521 n Decker Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male | COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina M. Schmidt

6 DATE OF BIRTH (month, day, and year) 2-2-56

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Central Iron Foundry

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christina Schmidt (Address) 521 N. Decker

15 MAR 15 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from March 13 1921 to March 13 1921, that I last saw h... alive on March 13 1921, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, 7

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation 1

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. H. Sowers, M. D.

March 15, 19 (Address) 601 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 3-16 1921

20 UNDERTAKER Philip Herrig

ADDRESS 2016 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—5-9-19—H. P. Co.—1000 Bks.

D 51887 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51887

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2307 Ashland Av St.) 7 (WARD) 150

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Child of John & Wilhelmina Miller

(a) RESIDENCE. No. 2307 Ashland ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Sing'l

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-14-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Wilhelmina Elgert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Miller (Address) 2307 Ashland Av

15 Filed MAR 15 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to March 14, 1921, that I last saw her alive on March 14, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

1 Incomplete Closure of Foramen Ovale

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm. E. Lingenfelter, M. D.

3/17, 1921 (Address) 1613 E. Fifth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3-15 1921
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Aisquith

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51888 HEALTH DEPARTMENT—CITY OF BALTIMORE D51888

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1944 Harlem Ave. ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Lovejoy

(a) RESIDENCE. NO. 1944 Harlem Ave ST., WARD.

(Usual place of abode) 4a

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Mulatto	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 4 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER Adam Main

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Miss Bushey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. H. A. Mettee
(Address) 1645 Cliftview Ave

15 Filed MAR 15 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1921, to March 13, 1921, that I last saw h[illegible] alive on March 13th, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1944 Harlem Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm E. Bodie, M. D.

Mar 15 1921 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak (Dawn) Cemetery	March 16 1921
20 UNDERTAKER	ADDRESS
Henry Hoen & Son	1201 E Eager St

CAUSE OF DEATH in plain terms, No abbreviations or terms. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51889

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51889

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 Brayton alley ST.: 11 WARD)

2-FULL NAME James H Billups

(a) RESIDENCE. No. 115 Brayton Ale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs 2 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Billups

6 DATE OF BIRTH (month, day, and year) Dec. 26 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairy - milk

(b) General nature of Industry, business, or establishment in which employed (or employer) Pasteurizer

(c) Name of employer Western Md - Dairy

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Seymore Billups

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie Hunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Eva Billups
(Address) 115 Brayton St

15 FILED MAR 15 1921 ROBERT I. CRAWFORD Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1921, to Mar 13, 1921, that I last saw h.. alive on Mar 13, 1921, and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Alterman, M. D.

, 19 (Address) 817 Hamilton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Auburn Cem	Mar 16 1921
20 UNDERTAKER	ADDRESS 578
Samuel Hensley	W Balto

578

CAUSE OF DEATH in plain terms. Indefinite answers, such as "Heart Failure," "Paralysis," "Old Age," "Convulsions," "Cancer," "Consumption," "Fever," "Dropsy," "Tumor," "Abscess," "Childbirth," "Accident," "Suicide," "Homicide," "Drowning," "Fracture," "Burns," "Scalds," "Poisoning," "Asphyxiation," "Hemorrhage," "Septicemia," "Pyemia," "Uremia," "Meningitis," "Peritonitis," "Pneumonia," "Bronchitis," "Nephritis," "Hepatitis," "Enteritis," "Colitis," "Appendicitis," "Hernia," "Obstruction," "Perforation," "Ulceration," "Gangrene," "Necrosis," "Embolism," "Thrombosis," "Aneurism," "Rupture," "Laceration," "Contusion," "Shock," "Collapse," "Coma," "Delirium," "Insanity," "Epilepsy," "Tetanus," "Hydrophobia," "Rabies," "Anthrax," "Glanders," "Farcy," "Actinomycosis," "Trichinosis," "Cysticercosis," "Echinococcosis," "Filariasis," "Ankylostomiasis," "Schistosomiasis," "Leishmaniasis," "Trypanosomiasis," "Spirochetosis," "Relapsing Fever," "Weil's Disease," "Rat-bite Fever," "Trench Fever," "Typhus Fever," "Rocky Mountain Spotted Fever," "Tsutsugamushi Disease," "Scrub Typhus," "Q Fever," "Psittacosis," "Ornithosis," "Lymphogranuloma Venereum," "Granuloma Inguinale," "Chancroid," "Gonorrhea," "Syphilis," "Yaws," "Pinta," "Endemic Syphilis," "Leprosy," "Tuberculosis," "Actinomycosis," "Nocardiosis," "Streptothricosis," "Mycetoma," "Madura Foot," "Maduromycosis," "Eumycetoma," "Actinomycetoma," "Chromoblastomycosis," "Rhinosporidiosis," "Coccidioidomycosis," "Histoplasmosis," "Blastomycosis," "Cryptococcosis," "Candidiasis," "Aspergillosis," "Mucormycosis," "Sporotrich

D51890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51890

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No.... 1112 Olive St. ST.: 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Fields.(C)

(Residence in Baltimore: No. 1112 Olive St.

50 ---------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH, ... Do not know. (Month) ....., 1 (Day) ..... (Year)

7-AGE, ...59.... yrs. ---- mos. ---- ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, James Griffin.(C)

11-BIRTHPLACE OF FATHER (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER Maria Griffin.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aletha Johnson.(C)daughter.

(Address) 1112 Olive St.

15- Filed MAR 15 1921 [illegible] Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March 12th. 1921. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Otto M. Eisenhardt M. D. (Coroner.)

March 14 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cad. DATE OF BURIAL, Mar. 15 1921

20-UNDERTAKER Samuel Hemsley ADDRESS 478 W. Biddle St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Date of death important. See instructions on back of certificate.

251891 HEALTH DEPARTMENT—CITY OF BALTIMORE 251891

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Metropolitan (Orchard Square) M. E. Church, 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Watts

(Residence in Baltimore: No. 574 W. Preston St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, November (Month) ..... (Day), 1861 (Year)

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Calvert Co, Md.

PARENTS.

10-NAME OF FATHER, Wm. Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mahoney

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aaron Watts

(Address) 574 W. Preston St.

15-

Filed MAR 15 1921 ROBERT J. KRAUTH Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

110 minutes (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no history

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. O'Hennessy M. D. (Coroner.)

March 14, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Mar. 17 19 21

20-UNDERTAKER Samuel Stemley

ADDRESS 3 B & M Bldg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51892

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51892

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 E. Monument ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harris Gold.

(a) RESIDENCE. NO. 1013 E. Monument ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Gold

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 56 Months Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Louis Gold 1411 E. Baltimore St.

15 Filed MAR 15 1924 ROBERT A KRAUTER Registrar

Burial Permit 61858

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 14 1924

17 I HEREBY CERTIFY, That I attended deceased from June 22, 19 17, to March 14, 19 24,

that I last saw h alive on March 14, 19 24,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Tubular Heart Disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) John Ostrich, M. D.

3/14/24, 19 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Rosedale	3/15 19 24
20 UNDERTAKER	ADDRESS
Jack Levis	1411 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Use other side if necessary. Do not use abbreviations or ditto marks. Omissions will delay the issuance of certificates. TION is very important. See instructions on back of certificates.

D51893 HEALTH DEPARTMENT—CITY OF BALTIMORE D51893

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 129 Albemarle St.; 2 WARD)
REGISTERED No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Leigel
(Residence in Baltimore: No. 129 Albemarle St; 30 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1853 (Year)

7-AGE: 68 yrs. — mos. — ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): (37)

9-BIRTHPLACE, (State or Country): Russia

PARENTS.
10-NAME OF FATHER: Unknown
11-BIRTHPLACE OF FATHER (State or Country): Russia
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jack Lewis
(Address) 1411 E Balto St

15-
Filed MAR 15 1921, 191.....
FOREST I. KRAUSE
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Unnecessary (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs.....mos.....ds.

(Signed) Sheldon Lyon Hurley M. D.
(Coroner)
March 15 1921 (Address) 8004 Eastwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Hebrew Rodeph Shalom
DATE OF BURIAL: 3-15 1921

20-UNDERTAKER: Jack Lewis
ADDRESS: 1411 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51894 HEALTH DEPARTMENT—CITY OF BALTIMORE D51894

CERTIFICATE OF DEATH.

6-09

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 S. Third St. ST.: 16 WARD)

2-FULL NAME Loretta Goeller

(a) RESIDENCE. NO. 936 S. Third St. ST., 16 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 29-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Goeller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Baier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) George Goeller 936 S. Third St.

15 FILED MAR 15 1921 [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch. 11, 1921, to Mch 15, 1921, that I last saw h[illegible] alive on Mch. 14, 1921, and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Measles.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Frank A. Glantz, M. D.

, 19 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	March 16 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH to be plainly written. Avoid use of abbreviations or local terms. Statement of contributory cause of death is very important. See instructions on back of certificates.

D-51895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-51895

REGISTERED No. C 410

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Md. Gen. Hosp. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry N. Baumgarten

(Residence in Baltimore: No. 1628 Madison Ave St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, Sept. 1, (Month) (Day), 1859 (Year)

7-AGE, 61 yrs. 6 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: cigar clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Wash. D.C.

PARENTS.

10-NAME OF FATHER, Julius Baumgarten

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lizzie Hepter

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Baumgarten

(Address) Wash. D.C.

15- MAR 15 1921 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 14, (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said his (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia, following cellulitis of buttocks & scrotum.

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Para-rectal abscess

(Duration) yrs. mos. 14 ds.

(Signed) J. J. T. Hennessy (Coroner.) M. D.

March 14, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1628 Madison Ave.

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL, Beth Hebrew — DATE OF BURIAL, 3-15-, 1921.

20-UNDERTAKER David Sondheim — ADDRESS 178 W Mt Royal

N. B. Every certificate must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 9-19—H. P. Co.—1000 Blks.

D 51896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51896

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH US. Public Health Service Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert L. Coleman

(a) RESIDENCE. No. US. Public Health Service Hosp. ST.. WARD. 56

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45 yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edna T. Kimbrough Registrar

(Address) US. Public Health Hosp. #56

15 [illegible] MAR 15 1921 [illegible] Registrar

Burial Permit 01874

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1921, to March 13 1921, that I last saw him alive on March 13. 1921, and that death occurred, on the date stated above, at 2 a.m. m.

The CAUSE OF DEATH* was as follows:

Myocarditis acute

unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam. Clinic report.

(Signed) Thomas R. Payne, M. D.
Senior Surgeon (R)

3/14/21 (Address) US. PHS. H. 56 FT. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Mar 15 1921
20 UNDERTAKER	ADDRESS
S. Thomson Bro	E Balto St

CAUSE OF DEATH in plain terms, so that it may be understood by the people in general. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51897

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 24 WARD) 36

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME illain W. Gallaher

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH If plain terms, so that a non-medical person can understand. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40 yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Registrar

(Address) US. Public Health Hosp. #56

15 FILED MAR 15 1921 [redacted] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1921

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1921, to March 14, 1921, that I last saw him alive on March 14, 1921, and that death occurred, on the date stated above, at 5:50 p.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia,

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of -----

Was there an autopsy? Yes.

What test confirmed diagnosis? Exam. Clinic report.

(Signed) Thomas R. Payne, M. D.

Senior Surgeon (R)

, 19 (Address) US. PHS. Hosp. #56 Ft McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlestown W. Va.	Mar 15 19 21
20 UNDERTAKER	ADDRESS 1127 E Baltimore St
S. Guerrant Bro	

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51898

CERTIFICATE OF DEATH.

D 51898

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 N. Eden St.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bacoate

(a) RESIDENCE. NO. 528 N. Eden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	-

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) March 10, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) 528 N. Eden St.
(State or country)

PARENTS

10 NAME OF FATHER Will Bacoate

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER Isadora Johnson

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant J. O. Gamble Mot.
(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 15 1921 [illegible] Registrar
Burial Permit Issued Commissioner of Health.
[illegible] WOODALL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 12, 1921, that I last saw h[illegible] alive on March 11, 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) 1 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Congenital Syphilis

(duration) — yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy N. Cromwell, M. D.

3/12 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	MAR 14 1921
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH must be stated plainly, and as fully as possible. See instructions on back of certificates. TION is very important.

17998

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51899

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cole

(a) RESIDENCE. NO. Johns Hopkins Hospital. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	B.	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/9/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Wm Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ella Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant J. Ortodinsky
(Address) Johns Hopkins Hosp.

15 Filed MAR 15 1921 Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1921

17

I HEREBY CERTIFY, That I attended deceased from 3/9/21, 19..., to 3/11/21, 19...,

that I last saw h. alive on 3/11/21, 19...,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. L. Stone, M. D.

3/12, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,
Per. Wm F. WOODALL

ADDRESS MAR 14 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 51900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51900

CERTIFICATE OF DEATH.

5 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walterman Peterson

(a) RESIDENCE. No. 413 N. Spring St. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Indies

PARENTS

10 NAME OF FATHER Christian Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed MAR 15 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921 to March 14, 1921.

that I last saw him alive on March 14, 1921.

and that death occurred, on the date stated above, at 11:15 A.m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) V Peterman M. D.

3/14/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Mar 17 1921
20 UNDERTAKER Pat Henry Smith	ADDRESS 133 Druid Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or ditto marks. Statement of contributory cause of death may be required. See back of certificates. INFORMATION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51901

CERTIFICATE OF DEATH.

10

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Montebello Terrace ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Arthur Mears

(Residence in Baltimore: No. 108 Montebello Terrace St.; ..... yrs., 6 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Single

6-DATE OF BIRTH, Aug (Month) 15 (Day), 1920 (Year)

7-AGE, ... yrs. 6 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Arthur G. Mears

11-BIRTHPLACE OF FATHER (State or Country) Accomac Co Va

12-MAIDEN NAME OF MOTHER Ruth C. Walker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur G. Mears

(Address) 108 Montebello Terrace

15-

Filed ..... Robert P. Harrison, Registrar.

MAR 15 1921 Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 14 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1921, to March 14 1921, that I saw h.. alive on March 14 1921, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

from Grippe to pneumonia (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Jameson M. D.

March 14, 1921. (Address) 4706 Hampden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, March 17, 1921

20-UNDERTAKER Jos B Cook

ADDRESS 1003 N Bal St

D. 51902 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 156

CITY OF BALTIMORE (No. 2736 Pennsylvania Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard H. Betts

(Residence in Baltimore: No. 2736 Pennsylvania Ave St.; 52 yrs., mos. ds.)

Cause of death to be properly classified. Exact statement of cause important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, October 19, 1868 (Month) (Day) (Year)

7-AGE, 52 yrs. 4 mos. 26 ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Betts

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Elinor Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. H. Betts

(Address) 2736 Pennsylvania Ave

15- Robert P. Harrison, Registrar.

Filed MAR 15 1921, 191.....

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 14, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by inhalation of illuminating gas (about 1 hr.) (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Hennessy (Coroner.) M. D.

March 14, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, March 16, 1921

20-UNDERTAKER Millard B Callender — ADDRESS 13 and 15 Ann St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51903 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51903

CERTIFICATE OF DEATH. 64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1324 Entaw Place ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura M. Calvert

(a) RESIDENCE. No. 1324 Entaw Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William N Calvert

6 DATE OF BIRTH (month, day, and year) Aug 31 - 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Hunt

11 BIRTHPLACE OF FATHER (city or town) Balti
(State or country) md

12 MAIDEN NAME OF MOTHER Badelia Drew

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

11 Informant Mrs R.C. Holland

(Address) 325 Roland Ave

15 Filed MAR 15 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1st 1921, to March 13 1921,

that I last saw h[illegible] alive on March 13 1921,

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis - Nephritis

Edema, Cardiac (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? No Special Test

(Signed) [illegible] M. D.

, 19 (Address) Eutaw Apts. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Mar 16 1921

20 UNDERTAKER John O. Mitchell — ADDRESS 1201 W Fayette

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 5 1904

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 5 1904

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2952 Presstman ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna S. Dorney

(a) RESIDENCE. No. 2952 Presstman ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20. 1901

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
19	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Henry G. Dorney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Jennie H Foster

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Herbert G Dorney (Address) 2952 Presstman St

15 Filed . 19 Robert F. Morrison Registrar

MAR 15 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1st. 1920 to March 14th. 1921, that I last saw h W alive on March 13th. 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hyam D. Perkins M. D.

. 19 (Address) 1141 E Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	Mar 17 1921
20 UNDERTAKER John O. Mitchell	ADDRESS 1201 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. If under 1 day, hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Charlie Lewis)

Spec.—8-24-14—M. & T.—2000 Bks.

D.51905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51905

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Argyle ave St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlie Lewis

(Residence in Baltimore: No. 1006 Argyle ave St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... 1882 ....., 1 .....
(Month) (Day) (Year)

7-AGE, 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Washington Lewis

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bruce Lampton

(Address) 117 E Baltimore St

15- Robert P. Harrison,

Filed ....., 191..... Burial Permit Clerk Registrar.

APR 15 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH March 14th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 17th, 1921, to March 14th, 1921, that I saw h— alive on March 14th, 1921, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Probably T. B.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. Fry Ellis M. D.

March 17th, 1921 (Address) 724 Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Lakeville Va

DATE OF BURIAL, March 16, 1921

20-UNDERTAKER David Everton

ADDRESS 916 Pa Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.51906

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 Coser St ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonina Lyzinantka

(a) RESIDENCE. NO. 2228 Coser St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Lyzinantka

6 DATE OF BIRTH (month, day, and year) April [illegible] 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 37

(b) General nature of industry, business, or establishment in which employed (or employer) Farm

(c) Name of employer Same

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jos. Jankin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Joseph Lyzinantka 2228 E. Coser St.

15 Filed MAR 15 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1921

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1921, to March 13, 1921, that I last saw h.r alive on March 13, 1921, and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation 24 hours

(duration)

CONTRIBUTORY (Secondary) Bronchitis acute (duration) ..... yrs. ca. 14 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? ns Date of

Was there an autopsy? ns.

What test confirmed diagnosis? Accultation, palpation

(Signed) H A Jamison Jr, M. D.

9/14, 1921 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary, Trappe Md	March 1921
20 UNDERTAKER	ADDRESS
Wendell & Lippert	1m 37 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.51907 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51907

CERTIFICATE OF DEATH.

176

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2342 E. Monument St.: 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adolph Fribe

(Residence in Baltimore: No. 2342 E. Monument St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word) Single

6-DATE OF BIRTH, Aug 3, 1870 (Month) (Day) (Year)

7-AGE, 50 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julius Doeller

(Address) 2342 E. Monument St.

15- Robert [illegible], 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Nephritis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D. (Coroner)

5-18, 1921 (Address) 4 Gales

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery

DATE OF BURIAL, March 16, 1921

20-UNDERTAKER Jas C. Miller

ADDRESS 2334 Jefferson St

MAY 15 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omit abbreviations. Every item important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51908

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2856 N Ramsay ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Francis Hartzell

(a) RESIDENCE. No. 2856 N Ramsay ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 0 mos. 4 ds. How long in U. S., if of foreign birth? 30 yrs. — mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Viverna Hartzell

6 DATE OF BIRTH (month, day, and year) May 4 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rogers Bros

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel R Hartzell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma McDowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Samuel R Hartzell

(Address) 2856 N Ramsay

15 Filed MAR 15 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1921

17 I HEREBY CERTIFY, That I attended deceased from March 6th, 1921, to Mar. 14th, 1921, that I last saw him alive on Mar. 13th, 1921, and that death occurred, on the date stated above, at 1. a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. L. Dickson, M. D.

19 (Address) 3055 N. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 16 1921
20 UNDERTAKER	ADDRESS
H. J. Tuckwell Sons	North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51909 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2511 Francis ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Witmyer

(a) RESIDENCE. No. 2511 Francis ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry D Witmyer

6 DATE OF BIRTH (month, day, and year) Apr. 9 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER Wm Chamberlain

11 BIRTHPLACE OF FATHER (city or town) (State or country) D.C.

12 MAIDEN NAME OF MOTHER Worthington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Florence Brown

(Address) 2511 Francis St

15 Filed 19 Robert P. Harrison, Registrar

MAR 15 1921 Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19 21, to Mar 15 21,

that I last saw her alive on Mar 15 1921,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D S Lloyd, M. D.

, 19 (Address) 2232 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Mar 18 1921
20 UNDERTAKER	ADDRESS
Wm Tuckerthons	Norfolk Va

Spec. 6-9-18—H. P. Co.—1000 Blks.

D 51910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51910

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 Madison Ave ST.. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Hy. Stevens

(a) RESIDENCE. No. 2125 Madison Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29/20

7 AGE Years	Months	Days	LESS than 1 day, hrs. or min.
	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Earl Hy. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Kate F. Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant (Address) 2125 Madison Ave.

15 MAR 16 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 13, 1921, to Mch 15, 1921, that I last saw he alive on Mch 15, 1921, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronch. Comp. of Pneumonia 2 Yrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) E A Smith, M. D.

3/15/21 (Address) 1605 N Monroe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Mch 17 1921

20 UNDERTAKER D J Marshall ADDRESS 3539 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51911 D51911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 96

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Adele Klaustaleck.

(a) RESIDENCE. No. 1400 Block Linden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Klaustaleck

6 DATE OF BIRTH (month, day, and year) March 1824

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	97			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Church Home Inf

(Address) Broadway

MAR 16 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Sep. 1920. to Mar. 14. 1921. that I last saw her alive on Mar. 11. 1921. and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Asthma

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chest & xam.

(Signed) Neil Grant M. D.

, 19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Mar 16 1921
20 UNDERTAKER	ADDRESS
W M Routson	2301 Greenmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. FULL NAME must be given. Fill out all items. Use ink. Write plainly. Do not abbreviate. Answer every question. Be sure to read carefully the instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51912 HEALTH DEPARTMENT—CITY OF BALTIMORE D51912

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10 Madfelt Ave ST. 13 WARD)

2-FULL NAME Charels W Downin

(a) RESIDENCE. No. 10 Madfelt Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarh E Downin

6 DATE OF BIRTH (month, day, and year) Jan 1 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Unknown

14 Informant Sarh Downin

(Address) 10 Madfelt Ave

15 FILED MAR 16 1921 Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1921

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to March 15, 1921, that I last saw him alive on March 15, 1921, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

acute Cardiac dilatation

1 hour

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L Schwartz M. D.

3/15 1921 (Address) 865 - W. 36" St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	March 17 21

20 UNDERTAKER ADDRESS

Chenoweth & Son Chestnut Ave

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 57913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57913

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reba Hoshall

(a) RESIDENCE. No. 2905 Huntington ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 17 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Swan Shoe Co.

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Hoshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co.

12 MAIDEN NAME OF MOTHER Rachael Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co.

14 Informant Frank Hoshall
(Address) 2905 Huntington Ave

15 MAR 16 1921 [illegible] KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1920

17

I HEREBY CERTIFY, That I attended deceased from Mar 10, 1921, to Mar 15, 1921, that I last saw h[illegible] alive on Mar 15, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Mar 11, 1921

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Lyman S. Abbott, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hereford Md	March 17 1921

20 UNDERTAKER	ADDRESS
Ehenowith Son	Chestnut Ave

mation SHOULD be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51914 HEALTH DEPARTMENT—CITY OF BALTIMORE. D 51914

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Montford ave ST.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma C. Maguire

(Residence in Baltimore: No. 1115 N Montford ave St.; 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, ~~Female~~ Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, dont Know ....., 1 .....
(Month) (Day) (Year)

7-AGE, 71 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md Balto

PARENTS.

10-NAME OF FATHER, Henry Lightner

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Mosser

(Address) 1442 N Gay St

15- Filed MAR 16 1921 191.. ROBERT J KRAUTER Registrar.

Burial Permit Issued.

CAUSE OF DEATH must be filled in by the physician. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 15, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1921, to Mar 15 1921, that I saw h[er] alive on Mar 14 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY.....
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Walter W Mosser M. D.

3/15, 1921 (Address) 2800 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Mar 17, 1921

20-UNDERTAKER Geo Mosser

ADDRESS 1442 N Gay St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51915

HEALTH DEPARTMENT—CITY OF BALTIMORE

642 D 51915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 Hampden Ave ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph T. Bowers Sr

(a) RESIDENCE: NO. 2811 Hampden ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Bowers

6 DATE OF BIRTH (month, day, and year) Mar 19-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Saml Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant J. T. Bowers Jr

(Address) 2811 Hampden Ave

15 Filed MAR 16 1921 ROBERT J. KRAFFT Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to March 13, 1921, that I last saw him alive on March 13 1921, and that death occurred, on the date stated above, at 1 30 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

*18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Heavey M. D.

3/14/1921 (Address) 2600 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dodon Royal Cem	Mar 16 1921
20 UNDERTAKER	ADDRESS
J Henrigt & Co	2008 Orleans

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, Etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Boerner D 51916

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51916

HEALTH DEPARTMENT—CITY OF BALTIMORE

Baltimore Md 47

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 527 E. 22nd St.

CITY OF BALTIMORE: (NO. ↗ ST.: 9th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Boerner

(a) RESIDENCE. NO. 527 E. 22nd ST., 9th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Henry F. Boerner

6 DATE OF BIRTH (month, day, and year) Jan 17, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Ralph Verberg

11 BIRTHPLACE OF FATHER (city or town) Holland (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Holland (State or country)

14 Informant Henry F Boerner

(Address) 527 E 22nd St.

15 Filed MAR 16 1921 19.... ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1921, to Mar 14, 1921, that I last saw her alive on Mar 14, 1921, and that death occurred, on the date stated above, at 6:25 P.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

1 hr.

(duration) ....yrs. ....mos.

CONTRIBUTORY (Secondary) Acute Endocarditis - Rheumatism (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. J. Roberts, M. D.

, 19 (Address) 451 E. 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	March 16 1921
20 UNDERTAKER E. A. Winfield Jr	ADDRESS 501 E 22nd

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46821 D 51917

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 51917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 11 WARD)

2-FULL NAME Lydia Cole

(a) RESIDENCE. No. 412 W Preston St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. Life ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt-County Md

12 MAIDEN NAME OF MOTHER: Mary Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hosp. Records. HOMER S. BRAUTER

15 Filed MAR 16 1921 Burial Permit Issued ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/12/21, 19..., to 3/14/21, 19..., that I last saw h[illegible] alive on 3/14/21, 19..., and that death occurred, on the date stated above, at 8.15 p.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical & pathological findings

(Signed) Edward L. Babington, M. D.

3-14, 19 21 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	Mar 18 1921
20 UNDERTAKER	ADDRESS
Samuel Hemsley	58 N Bridle

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D57918 HEALTH DEPARTMENT—CITY OF BALTIMORE D51918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 142

CITY OF BALTIMORE: (No. New City Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George T. Johnson

(a) RESIDENCE. NO. ~~Unknown~~ 767 Vine ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced. HUSBAND of ~~or WIFE of~~ Louisa Johnson ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 0?1

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) New City Hospital

15 Filed MAR 16 1921 ROBERT A. BAUER Registrar Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 27, 1921 to March 12, 1921, that I last saw him alive on March 11, 1921, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Gangrene of right leg. (senile)

(duration) yrs. 3½ mos. ds.

CONTRIBUTORY (Secondary) Pulmonary embolus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? yes Date of 2-28-21

Was there an autopsy?

What test confirmed diagnosis? examination.

(Signed) J. A. Holden, M. D.

3/13/21 (Address) New City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Mar 16 1921
20 UNDERTAKER	ADDRESS
Samuel Hensley	2 N. Bond

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 57919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 15 WARD) 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Flax

(a) RESIDENCE. NO. 1521 N. Carey St. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Flax

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital

15 MAR 16 1921 ROBERT J. TREUTEL Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from December 16, 1919, to March 13, 1921, that I last saw h im alive on March 13, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Arteria - sclerosis (old cerebral thrombosis)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopical test.

(Signed) [illegible], M. D.

3/14/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Auburn, Cem. Mar 17 20

20 UNDERTAKER — ADDRESS

Samuel T. Hendley 5[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

D51920

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 51920

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 208 W Monument St. 11 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Dr William David Booker

(Residence in Baltimore: No. 208 W Monument St. St.; 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Nov 11th, 1844 (Month) (Day) (Year)

7 AGE: 76 yrs. 4 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Doctor
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Va

PARENTS

10 NAME OF FATHER: James M Booker

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: L. A. Morton

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm D Booker

(Address) 208 W Monument St.

15 THIS MAR 16 1921 ROBERT A KRAUTH Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 15th, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 6th 1921, to March 15th 1921, that I saw him alive on March 15th 1921, and that death occurred, on the date stated above, at 10.20 A.m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 10 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm F. Lockwood M. D.

Mar 16, 1921 (Address) 8 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Greenmount	March 16, 1921
20 UNDERTAKER	ADDRESS
J Q Lucas & Co	Greenmount Ave & Oliver St

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D51921 HEALTH DEPARTMENT—CITY OF BALTIMORE D51921

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 202 Read St ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia D'arcy Wetmore

(a) RESIDENCE. No. 202 Read St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~ ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas J Wilson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Maria D'arcy

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Md

14 Informant James T Wilson (Address) 871 Park Ave

15 Filed MAR 16 1921 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14th 1921.

17 I HEREBY CERTIFY, That I attended deceased from June 23rd. 1920, to March 14th 1921, that I last saw h... alive on March 14th 1921, and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

of several

years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Renal Insufficiency

2 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Epidiagnose

(Signed) Wm C. Rule, M. D.

3-15 1921 (Address) 1012 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL March 16 1921

20 UNDERTAKER Henry H Jenkins & Son Co

ADDRESS Orchard Mac-Pollok

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51922

CERTIFICATE OF DEATH.

REGISTERED NO. 428

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Warsche ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Johnson

(a) RESIDENCE. No. 729 Warsche ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Johnson

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator-man

(b) General nature of industry, business, or establishment in which employed (or employer) Factory 086

(c) Name of employer McCormick & Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Arthur Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Anne Johnson
(Address) 729 Warsche

15 Filed MAR 16 1921 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 30 1920, to March 15 1921, that I last saw h wife alive on March 13 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. S. McCard M. D.

3/15, 1921 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mch 17 1921
20 UNDERTAKER John H Toadvine	ADDRESS 142 N Fremont St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D51923 HEALTH DEPARTMENT—CITY OF BALTIMORE D51923

Pipes

105

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 928 N. Eutaw ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Amy Pipes

(a) RESIDENCE. No. 928 N. Eutaw ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Frederick Pipes

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Shorter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anna Chester

(Address) 928 N. Eutaw

15 Filed MAR 16 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/1921

17 I HEREBY CERTIFY, That I attended deceased from 2/22/1921, to 3/14/1921,

that I last saw h alive on March 13, 1921,

and that death occurred, on the date stated above, at 12:45 p.m.

The CAUSE OF DEATH* was as follows:

Pleural Effusion

about 7 ds.

(duration)

CONTRIBUTORY (Secondary) Chronic Catarrhal Gastro-Enteritis about 2 mos. + ds.

(duration)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jno. H. Tompkins, M. D.

3/16/1921 (Address) 1019 Reid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL March 16 1921

20 UNDERTAKER John A Treadwell

ADDRESS 142 Mosher St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51924

CERTIFICATE OF DEATH. X 92-120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 St. Central Avst.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph Triplett

(a) RESIDENCE. No. 1333 St Central Avst., WARD. Montrose W Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT CONDITION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, ~~or Divorced~~ (write the word)
Male	White	Widower

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Sarah Triplett

6 DATE OF BIRTH (month, day, and year) Aug 28 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) ~~odb~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER John Triplett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nancy Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Geo W Little

(Address) 2700 Edmondson Av

15 Filed MAR 16 1921 ~~BOYER J. LAUTER~~ Registrar ~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1921, to Mar 15, 1921, that I last saw him alive on Mar 15, 1921 and that death occurred, on the date stated above, at 1220 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Coma (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J Walla Thomas, M. D.

1921 (Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Montrose W. Va.	Mar 16 1921

20 UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Av

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51925 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D51925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Myrtle Av ST. 14 WARD)

REGISTERED No. 105

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Hughes

(a) RESIDENCE. No. 1416 Myrtle Av ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26, 1854

7 AGE 26 Years 10 Months Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas E. Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Read

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rachel Hughes

(Address) 1416 Myrtle Ave

15 FI... MAR 16 1925 ROBERT I. KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15 1925

17 I HEREBY CERTIFY, That I attended deceased from 3/15, 1925, to 3/15, 1925, that I last saw h[illegible] alive on 3/15, 1925, and that death occurred, on the date stated above, at 8 10 A m.

The CAUSE OF DEATH* was as follows:

Ac. Gastro-enteritis

(duration) yrs. mos. 8 ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burt Carter, M. D.

. 19 (Address) 2139 D. A. Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem | DATE OF BURIAL: Mar 24

20 UNDERTAKER: George H Holland | ADDRESS: 1631 Linden Ave

mation should be entered. Explain. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 5 1926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 5 1926

CERTIFICATE OF DEATH.

REGISTERED NO. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Clinton ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Mullen

(Residence in Baltimore: No. 119 S. Clinton St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Infant

6-DATE OF BIRTH, March (Month) 14th (Day), 1921 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 5 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... M.D.

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Daniel Mullen

11-BIRTHPLACE OF FATHER (State or Country), New Jersey.

12-MAIDEN NAME OF MOTHER Rose Regan

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Mullen

(Address) 119 S. Clinton St

15- Filed MAR 16 1921, 191.... ROBERT J. KRAUTER Registrar. Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch. 14 1921, to March 15 1921, that I saw him alive on March 15th 1921, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Premature Birth @ 6½ mths - ulter Gestation.

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) T. W. Keown M. D.

Mch 15, 1921 (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, 3-16-, 1921

20-UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto. St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2 51927 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 251927

CERTIFICATE OF DEATH. 91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Miller

(a) RESIDENCE. NO. Unknown 828 Light ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacco Stripper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER August Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed MAR 16 1921 ROBERT B. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to March 14, 1921, that I last saw him alive on March 14, 1921, and that death occurred, on the date stated above, at 5:40 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) V. Bosemann, M. D.

3/15/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	March 17 1921
20 UNDERTAKER E Schlosman & Son	ADDRESS 1034 Eliwood Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NAMES OF DISEASES ONLY. TUBERCULOSIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Devant

HEALTH DEPARTMENT—CITY OF BALTIMORE

D57928 ✓ D57928

D57928

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Devant

(a) RESIDENCE. NO. 255 N. East St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md.

PARENTS

10 NAME OF FATHER Philip Devant.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy.

12 MAIDEN NAME OF MOTHER Irene Salvi.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy.

14 Informant Johns Hopkins Hospital records
(Address)

15 MAR 16 1921 [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16. 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15. 1921, to March 16. 1921, that I last saw him alive on March 16. 1921, and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (laryngeal)

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Culture of throat

(Signed) [illegible] M. D.

. 19 (Address) J H H. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	March 21
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut av

CAUSE OF DEATH in plain terms, so that it may be properly classified. BLANK will not be accepted. See back of certificates.
TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-51929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-51929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Merc Hook. St.: 7691 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Charles McNeal

(a) RESIDENCE. No. 813 Belgian ave. St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt.	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew MacNeal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant David Mc Lean
(Address) 813 Belgian Ave

15 MAR 16 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15 1921

17

I HEREBY CERTIFY, That I attended deceased from 3/13, 1921, to 3/15, 1921, that I last saw him alive on 3/15, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Irwin D. Padgett, M. D.

3/16, 1921 (Address) Merc Hook.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	March 18 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. Hoffman ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-51930

D-51930

1-PLACE OF DEATH

REGISTERED NO. 1591

CITY OF BALTIMORE: (No. New City Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Hunter.

(a) RESIDENCE. No. 1702 Friendsbury Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life time mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt.	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Sweeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Joseph Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Victor Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records,
(Address) New City Hospital.

15 MAR 16 1921 ROBERT J. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1921, to March 14, 1921

that I last saw him alive on March 14, 1921

and that death occurred, on the date stated above, at 5:15 P.m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) V. B. Herman, M. D.

3/15/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	3/17 1921
20 UNDERTAKER	ADDRESS
William Cook	502 W. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D- 51931

CERTIFICATE OF DEATH.

D-51931

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2510 Hudson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna Bramley

(a) RESIDENCE. No. 2510 Hudson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Jesse A Bramley

6 DATE OF BIRTH (month, day, and year): July 2 1865

7 AGE — Years: 56 Months: 1 Days:

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Conrad Stumpf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Catherine Fogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Jesse A Bramley

(Address): 2510 Hudson St

15 Filed MAR 16 1921 19 ROBERT I KRAUSE Registrar

Racial Form II Color

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Mch 14, 1921, that I last saw h[er] alive on Mch 12, 1921, and that death occurred, on the date stated above, at 10 6[0] m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Dilated heart

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. McAvoy, M. D.

, 19 (Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Mar[ch] 19

DATE OF BURIAL

20 UNDERTAKER: Wm Cook

ADDRESS: 512 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

D-51932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-51932

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2219 Booth ST.; 20 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Neale

(a) RESIDENCE. No. 2219 Booth ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 6 mos. 17 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo H. Neale

6 DATE OF BIRTH (month, day, and year) Aug 25-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County-Md

PARENTS

10 NAME OF FATHER Adam J Link

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Seamon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John A. Neale
(Address) 2219 Booth St

15 Filed ....., 19.....

MAR 18 1921 ROBERT E LEE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 13, 1921, to Mar 14, 1921, that I last saw h Exclusive on Mar 13, 1921, and that death occurred, on the date stated above, at 6.2, m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Endocarditis Annual

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly, M. D.

3/15. 1921 (Address) 1127 Orchard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Mar 18 21
20 UNDERTAKER	ADDRESS
H B Nippert	2236 Fredk Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations not allowed. Any additional information may be given on back of certificates. TION is very important. See instructions on back of certificates.

D 51933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51933

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2194 Mount ST. 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha E. Crow

(Residence in Baltimore: No. 2194 Mount St. 1 yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, May 21, 1838
(Month) (Day) (Year)

7-AGE, 82 yrs. 9 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Wm Beazley

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Elizabeth Burk

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Mallory Dietrich

(Address) 2194 Mount St.

15-

Filed MAR 16 1921, 191.... ROBERT B. KRAUTH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

(Signed) James M. Tenbrook M. D.
(Coroner.)

May 15, 1921. (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loppahannock Essex Co. Va. DATE OF BURIAL, Mar 17/21

20-UNDERTAKER W. Cal ADDRESS 5026 Natl Ave

N. B.—Every item of information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D-51934 HEALTH DEPARTMENT—CITY OF BALTIMORE D-51934

CERTIFICATE OF DEATH.

1818

1-PLACE OF DEATH Globe Ship Building Co. REGISTERED NO. C.....

CITY OF BALTIMORE (No. Fairfield. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nelson O Hodges.

(Residence in Baltimore: No. 1422 Battery Ave. St.; 7 yrs., ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, ..May 17th. 1903....., 1.....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
..17..yrs..9..mos..26..ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Rivet passer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Rock Hall Kent Co. Md.

PARENTS.

10-NAME OF FATHER, Richard Hodges.

11-BIRTHPLACE OF FATHER (State or Country) Rock Hall Kent Co. Md.

12-MAIDEN NAME OF MOTHER Minnie Downey.

13-BIRTHPLACE OF MOTHER (State or Country), Rock Hall Kent Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Hodges. (father)

(Address) 1422 Battery Ave.

15- MAR 16 1921 COUNTY S [illegible]
Filed....., 191.... Special Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..March 15th. 1921....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..inquiry.. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) ..inquiry.. find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

..Accidentally electrocuted by coming in contact with electric light wire while at work.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto H. Feinhardt M. D.
(Coroner)

March 15 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Rock Hall - Md	March 17, 1921
20-UNDERTAKER	ADDRESS
William Cook	502 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WHITE INK

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51935

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51935

CERTIFICATE OF DEATH.

92-129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Tyler

(a) RESIDENCE. NO. 883 Tyson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Aug 22, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Archibald Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Josephine Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Josephine Tyler 883 Tyson St

15 Filed MAR 16 1921 CORNELIUS A. KELLY Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/1 1921, to 3/15 1921, that I last saw her alive on 3/15 1921, and that death occurred, on the date stated above, at 12.05 a.m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroid

(duration) ? yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) General Peritonitis 4 and 2

Lobar Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/7 Hysterectomy

Was there an autopsy? Yes Gynatric Fundings

What test confirmed diagnosis?

(Signed) Lewis A. Radcliffe, M. D.

3/16 1921 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cmty	3/18 1921
20 UNDERTAKER Mrs Root & Elliott	ADDRESS 725 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51936

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51936

REGISTERED NO.....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 632 Vine ST.: 4 WARD)

2-FULL NAME Chas Wm Gittings

(a) RESIDENCE. NO. 632 Vine St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Gittings

6 DATE OF BIRTH (month, day, and year) apl 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hod Carrier 035

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Northumberland Co Va

PARENTS

10 NAME OF FATHER John Gittings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Jorgana Gittings 632 Vine st

15 Filed MAR 16 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 14 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 12, 1921, to Mch 14, 1921, that I last saw him alive on Mch 13, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (duration) 3 ds.

CONTRIBUTORY (Secondary) ~~Phthisis~~ Endocarditis (duration) 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Gustav Goldman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cmtry	3/16/21
20 UNDERTAKER Mrs Robt a Elliott	ADDRESS 1726½ Ashland ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 61937

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51937

66-041

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Marquetta

(a) RESIDENCE. No. 1907 Alice Ann St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Isia Marquetta

11 BIRTHPLACE OF FATHER (city or town) (State or country) West India

12 MAIDEN NAME OF MOTHER Emery Everett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Hospital Records, (Address) New City Hospital

15 Filed MAR 16 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from December 23 1920, to March 13, 1921, that I last saw h... im alive on March 12, 1921, and that death occurred, on the date stated above, at 4:45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 1907 Alice Ann St.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No special test

(Signed) Jack. R. Morgan, M. D.

3/14/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's Cemetery DATE OF BURIAL 3/19 1921

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Mt Royal ave.

mation should be carefully supplied. Exact statement of occupa... it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

951938 HEALTH DEPARTMENT—CITY OF BALTIMORE 951938

CERTIFICATE OF DEATH.

REGISTERED NO. 8 79-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 N. Broadway ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Byrne

(a) RESIDENCE. No. 1706 N. Broadway ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
About	72	----	-----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daniel Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Chas J. Byrne
(Address) 1706 N. Broadway

15 Filed MAR 16 1921 19 ROBERT A KRAUER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to Mar. 16, 1921, that I last saw her alive on Mar. 15, 1921, and that death occurred, on the date stated above, at 7 A.M. The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia and Pleurisy

(duration) yrs. Abt. mos. 1 ds.

CONTRIBUTORY (Secondary) Valv. Disease of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Benj. F. Hayden, M. D.

3/16, 1921 (Address) 1210 N. Carrollton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 3/18/21.

20 UNDERTAKER: Chas. E. Evans & Son

ADDRESS: 118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No tuberculosis — Heart disease of long standing.

Spec.—8-24-14—M. & T.—2000 Bks.

D 51939

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51939

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 Valley ST.: 10 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Smith

(Residence in Baltimore: No. 1030 Valley St St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED;~~ (Write the word.) Married

6-DATE OF BIRTH, July (Month) 12 (Day), 1845 (Year)

7-AGE, 75 yrs. 8 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) At Home

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Dennis Moylan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER — Bailey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. A. Smith

(Address) 1030 Valley St.

15- MAR 16 1921 BOARD OF HEALTH

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 4 1921, to Mar 14 1921, that I saw her alive on Mar 14 1921, and that death occurred, on the date stated above, at 3.25 P.m.

The CAUSE OF DEATH* was as follows:

.....

.....

Lobar Pneumonia

..... (Duration) .....yrs. .....mos. 10 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Mary F. Vaughan M. D.

Mar. 15., 1921. (Address) 1028 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 3/17, 1921

20-UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Every certificate must be signed. Every item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51940

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51940

CERTIFICATE OF DEATH.

79-042

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 E Madison ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia M. Burton.

(a) RESIDENCE. NO. 10 E. Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widowed.

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Henry C. Burton.

6 DATE OF BIRTH (month, day, and year) Aug 10. 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Castle.
(State or country) Delaware.

PARENTS

10 NAME OF FATHER Judge James Booth

11 BIRTHPLACE OF FATHER (city or town) New Castle
(State or country) Delaware.

12 MAIDEN NAME OF MOTHER Hannah Rogers.

13 BIRTHPLACE OF MOTHER (city or town) New Castle
(State or country) Delaware.

14 Informant Julia M Burton
(Address) 10 E Madison St

15 Filed MAR 16 1921, 19 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to March 15, 1921, that I last saw her alive on March 15, 1921, and that death occurred, on the date stated above, at 10-15 P. m.

The CAUSE OF DEATH* was as follows:

Pleuro-Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Mitral heart disease

(duration) Many yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual physical signs

(Signed) Jno M. Cunningham, M. D.

, 19 (Address) Bath. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Castle Del.

DATE OF BURIAL Mar 17th 1921

20 UNDERTAKER Henry W. Jenkins Sons Co

ADDRESS McCulloh & Pachard Sts.

Information should be carefully supplied. Exact statements must be made. Every question must be properly answered. Physicians and undertakers should be careful that it may be properly classified. Exact statements must be made. Every question must be properly answered. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements must be made. Every question must be properly answered. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51941

CERTIFICATE OF DEATH.

10-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2307 Garrison Ave St.; 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis S Wade

(a) RESIDENCE. NO. 2307 Garrison Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? 7 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Ellen Wade

6 DATE OF BIRTH (month, day, and year) 4/7/1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chartered Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER James Wade

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ann Senior

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant John P. Wade

(Address) 2307 Garrison Ave.

15 Date MAR 16 1921, 19.. Robert J. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar - 15 - 1921

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1921, to Mar - 15, 1921, that I last saw him alive on Mar 15, 1921, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia, following what was probably influenza.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

3/16 1921 (Address) 2202 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	March 18, 1921
20 UNDERTAKER	ADDRESS
George J. Smith	1000 N. Fayette St.

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51942

CERTIFICATE OF DEATH.

170

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 Poplar Grove ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Lindsay

(Residence in Baltimore: No. 1026 Poplar Grove, St.; Lifetime yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May (Month) 10 (Day) 1845 (Year)

7-AGE, 75 yrs. 10 mos. 5 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Williams Jones

11-BIRTHPLACE OF FATHER (State or Country), Great Britain

12-MAIDEN NAME OF MOTHER Martha Trueman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W. Lindsay

(Address) 1026 Poplar Grove St

15- Robert P. Harrison, Registrar.

Filed ....., 191.....

Burial Permit Issued

MAR 16 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 15 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1921, to March 15 1921, that I saw h[er] alive on March 14 1921, and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza

(Duration) 10 days

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) J. M. Lemmon M. D.

March 11, 1921. (Address) 836 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, March 18, 1921

20-UNDERTAKER B. Schloman & Son

ADDRESS 937 Hanover

NOTE—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact duration of each disease important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51943 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51943

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gifford

(a) RESIDENCE. No. 417 W. Lanvale St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't know,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant George Gifford

(Address) Same 417 W. Lanvale St.

MAR 18 1921

Filed 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15/ 1921

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1921, to March 15, 1921, that I last saw him alive on March 15, 1921, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ll ll

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Charles A Donovan, M. D.

, 19 (Address) 5. E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	March 17-1921
20 UNDERTAKER William Cook	ADDRESS 502 S Hartem

Information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51944

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Wilkins Ave ST.; 19 WARD)

2-FULL NAME Emma Smith

(a) RESIDENCE. No. 1612 Wilkins Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Smith

6 DATE OF BIRTH (month, day, and year) Oct 10 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER George Ruckle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Emma Hall Balto

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Gill

(Address) 1617 E. Ft. Ave

15 Filed MAR 16 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 1 1921, to Mch 15 1921, that I last saw h[illegible] alive on Mch 14 1921, and that death occurred, on the date stated above, at 5-30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) E Gill Hall M. D.

Mch 16 1921 (Address) 1617 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Mch 17 1921
20 UNDERTAKER Wm Cook	ADDRESS 032 E Ft

mation should be carefully supplied. Age should be stated in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 51945 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51945

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1717 Westwood Ave (15 WARD) 20 REGISTERED NO.

2-FULL NAME Edith A. Hughes.

(a) RESIDENCE. NO. 1717 Westwood Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas H. Hughes

6 DATE OF BIRTH (month, day, and year): Aug 30 - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: James W. Ogle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ky

12 MAIDEN NAME OF MOTHER: Mary Ebbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Thomas H. Hughes 1717 Westwood Ave

15 Filed: MAR 16 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 4, 1921, to Mar. 13, 1921, that I last saw he alive on Mar 13, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Septic Sore throat

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. E. Dunnbock M.D.

19 (Address) 1531 E. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Monroe Bridge Md	March 17 1921

20 UNDERTAKER: Harry H. Holtzke ADDRESS: 1681 N. Longwood

Should be stated EXACTLY. ABBREVIATIONS should be carefully supplied. AGE it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.51946 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51946

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Somerset ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Busch

(Residence in Baltimore: No. 802 Somerset St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH. Feb (Month) 1st (Day), 1846 (Year)

7-AGE. 74 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Housework

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER. John Murray

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Fitzpatrick

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Busch

(Address) 802 Somerset St

15-

Filed ....., 191.....

Robert P. Barnes, Registrar.

(Burial Permit Clerk.)

MAR 16 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 12 1921, to March 15 1921, that I saw h[illegible] alive on March 15 1921, and that death occurred, on the date stated above, at 9.20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. E. Thomsteen M. D.

3/15, 1921. (Address) 733 Augusta St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cath Cem

DATE OF BURIAL, 3/17/21, 191...

20-UNDERTAKER Geo. J. Ruth

ADDRESS 1785 Harford Ave

N.B.—Every item of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Contributory Cause important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

20.51947

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.51947

CERTIFICATE OF DEATH.

92

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #1 Smallwood St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gallagher

(Residence in Baltimore: No. #1 Smallwood St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH, Jan. (Month) 6th (Day), 1853 (Year)

7-AGE, 68 yrs. 2 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Contractor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Gallagher

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Hughes

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Gallagher

(Address) #1 Smallwood St.

15-

Filed MAR 16 1921

Robert P. Harrison, Registrar.

Burial Permit Clerk.

N.B.—EVERY FACT stated in this certificate should be given in full and plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 10 1921, to March 14 1921, that I saw him alive on March 13 1921, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. Gell Hall M. D.

March 16, 191... (Address) 1617 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Holy Cross Cem. DATE OF BURIAL, 3/16/21, 191...

20-UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51948

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3411 Reisterstown Rd ST., 15 WARD)

2-FULL NAME Jacob Caplan

(a) RESIDENCE. NO. 3411 Reisterstown Rd ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 15 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Caplan

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31 32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hinkon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hinkon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1411 E Balt St

15 Filed MAR 17 1921 ... Registrar

Burial ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1920, to Mar. 16, 1921, that I last saw him alive on Mar 15, 1921 and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Starvation due to Tubercular Laryngitis

(duration) yrs. 11 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) several years

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? C. B. Sputa

(Signed) Joseph Kessler, M. D.

, 19 (Address) 1908 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 3/17 1921

20 UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt St

mation should be carefully supplied. Exact statement of OCCUPA
it may be properly classified, so that it may be
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on b
on back of certificates.

BALTIMORE CITY, STATE OF MARYLAND, to wit:

I HEREBY CERTIFY that on this 8th day of April, 1921, before me a Notary Public of the State of Maryland, in and for Baltimore city aforesaid, personally appeared Dr. Joseph Kemler, and made oath in due form of law that the correct age of Jacob Kaplan, late of Baltimore city, who died on March 16th, 1921, is thirty-one years and not thirty-two years as shown on the death certificate, the incorrect age having heretofore been furnished by me owing to a misunderstanding.

WITNESS my hand and Notarial seal.

Katharine E. Mueller
Notary Public.

Spec.—8-24-14—M. & T.—2000 Bks.

D51949

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51949

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3248 Barclay St ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. B. Walker

(Residence in Baltimore: No. 3248 Barclay St St.; Life yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Mar 15 (Month) (Day), 1892 (Year)

7-AGE, 28 yrs. 11 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Driver

9-BIRTHPLACE, (State or Country), born in Baltimore

PARENTS.

10-NAME OF FATHER, Peter I Walker

11-BIRTHPLACE OF FATHER (State or Country), born in Baltimore

12-MAIDEN NAME OF MOTHER Georgeanner Washington

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G Georgeanner Walker

(Address) 3248 Barkley St

15- MAR 17 1921 ROBERT J. BRAUTIGAM

Filed....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 14 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 14 1919, to March 14 1921, that I saw him alive on March 13 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs.... mos.... ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs.... mos.... ds.

(Signed) H W Gradders M. D.

3/16/21, 191... (Address) 321 E-25 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, March 17, 1921

20-UNDERTAKER Mrs Robert A Elliott — ADDRESS 1725 Eutaw St

N. B.—Every item must be properly classified. Exact information is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51950

CERTIFICATE OF DEATH.

5 108

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 345½ Forest ST.: 5 WARD)

2-FULL NAME Lizzie Green

(a) RESIDENCE. NO. 345½ Forest ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Albert Bacon

11 BIRTHPLACE OF FATHER (city or town) (State or country): N Carolina

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N Carolina

14 Informant (Address): Leora Miller 223 N Bond st

15 MAR 17 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-16-1921

17 I HEREBY CERTIFY, That I attended deceased from 3-15-, 1921, to 3-16-, 1921, that I last saw h. or alive on 3-15-, 1921, and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Cargill, M. D.

3-16, 1921 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	March 1921
20 UNDERTAKER: John W Henderson	ADDRESS 1602 E Monument

mation should be carefully supplied. Exact statement of occupa... may be properly classified, so that it may... CAUSE OF DEATH in plain terms, so that it... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51951

CERTIFICATE OF DEATH.

40

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 N. Regester ST.; 8 WARD)

2-FULL NAME Margaret S. Chalmers

(a) RESIDENCE. NO. 1707 N. Regester ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced — WIFE of Alexander Chalmers

6 DATE OF BIRTH (month, day, and year) Aug 30 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Mr. Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Chalmers
(Address) 1707 N. Regester St

15 Filed MAR 17 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan- 1, 1921, to Mch- 16, 1921, that I last saw her alive on, Mch 15, 1921, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. Gill Hill, M. D.

March 16. 1921 (Address) 1707 N. Regester St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 19 1921
20 UNDERTAKER	ADDRESS
Henry Horn & Son	130 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D51952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 30 E. Heath St. ST.: 23 WARD) REGISTERED No. C 79

2-FULL NAME John J. Ryan.

(Residence in Baltimore: No. 30 E. Heath St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

60 ---------- St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHRASES, such as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, Do not know. (Month) , 1 (Day) (Year)

7-AGE, 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Street sweeper
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Maine.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Ryan. (wife)

(Address) 30 E. Heath St.

15- MAR 17 1921 Filed, 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 15th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto C. Reinhardt M. D. (Coroner)

March 15, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, March 19 1921.

20-UNDERTAKER, M. J. E. Evans & Sons ADDRESS 1428 E. Baltimore St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51953

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 North Charles ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph Barton

(a) RESIDENCE. No. 914 N. Charles ST., 11 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced~~ (write the word)
M.	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or), WIFE of~~ Agnes K. Barton

6 DATE OF BIRTH (month, day, and year) 1844-4-27

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Winchester (State or country) Va

PARENTS

10 NAME OF FATHER David W. Barton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fanny L. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Randolph Barton Jr. (Address) 207 N. Charles St.

15 Filed MAR 17 1921 ... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1920, to Mar 15, 1921, that I last saw h. alive on Mar 15, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 4 mos.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter A Baetjer M. D.

, 19 (Address) 700 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL 3-17 1921

20 UNDERTAKER Stevens W Jenkins Co

ADDRESS W Fulton Orchard.

mation should be carefully supplied. Age should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-51954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Dr 95 1954

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1053 N Front ST.: 10 WARD)

2-FULL NAME Catherine Ford.

(a) RESIDENCE. No. 1053 N Front ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 17. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Kate Farinon
(Address) 1053 N Front

15 FILED MAR 17 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1921

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to March 12, 1921, that I last saw h or alive on March 12, 1921, and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) A. H. Hornstein, M. D.

3/15, 1921 (Address) 733 Augusta St

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar 18 1921
20 UNDERTAKER	ADDRESS
E J Fanning & Son	730 E Lafayette

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D51955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. on University Hospital ST.: 4 WARD) 75-00

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry D. Keyser

(Residence in Baltimore: No. 781 W. Pratt st.

St.(yrs., 1)(mos. 2 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, March (Month) 30 (Day), 1916 (Year)

7-AGE, 4 yrs. 11 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Herman V. Keyes

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Nannie Gibson

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman V. Keyes

(Address) 781 W. Pratt St

15- FILED MAR 17 1921, 191. ROBERT F. KRAUTER Registrar. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.)

thereon and from the evidence obtained by said ~~(Inquest, or~~ ~~autopsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull, instantly

Cuts, Neck (Duration) a few minutes

CONTRIBUTORY (Secondary) Struck by auto (Duration) a few minutes

(Signed) W. K. Gorman M. D. (Coroner.)

3-17, 1921 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Virginia

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Shenandoah Va	March 17 1921
20-UNDERTAKER	ADDRESS
W. M. Routson	2301 Greene

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51956

CERTIFICATE OF DEATH.

X 91

REGISTERED NO.

1-PLACE OF DEATH US. Public Health Hosp. "56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francisco Real

(a) RESIDENCE. NO. US. Public Health Hosp. Baltimore Md. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26 yrs.	---	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar Rosenberg Registrar

(Address) US. PHS Hosp. #56 Fort McHenry Md.

15 Filed MAR 17 1921 19 ROBERT I. KRAUTH Registrar

Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10 1921 19 , to March 16, 1921.

that I last saw him alive on March 16, 1921,

and that death occurred, on the date stated above, at 1'40 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia broncho

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of -----

Was there an autopsy? yes.

What test confirmed diagnosis? Exam.

(Signed) Thomas R. Payne M. D.

Senior Surgeon (R)

, 19 (Address) US. PHS Hosp. #56 FtMchenry Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Mar 17 1921

20 UNDERTAKER J. Livingston & Bro

ADDRESS 1121 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D51957

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/51957

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2215 Eutaw St. (Ward) 7

2-FULL NAME Frank Gryger (Grants Gryger)

(a) RESIDENCE. NO. 24 S Chapel St., 321 S. Chapel Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
~~(or WIFE of)~~ HUSBAND of Catharine Gryger

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) General.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Mathew Gryger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Catharine Gryger
(Address) 24 S. Chapel

15 Filed MAR 17 1921 ROBERT E. LAZEAR Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1921, to Mar 15, 1921, that I last saw h— alive on Mar 11, 1921, and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. Wallace, M. D.

(Address) 1 E. Read St. 1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus — DATE OF BURIAL 3/18/1921

20 UNDERTAKER Jacob Frackowiak — ADDRESS 618 E. Baltimore

N. B.—WRITE PLAINLY, with ink, and fully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be caref

D51958 HEALTH DEPARTMENT—CITY OF BALTIMORE. 19 D 51958

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 11 Cold Spring Ave. 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John. C. Parker

(Residence in Baltimore No. 11 Cold Spring Ave St.; yrs., 46 mos. 3 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, ~~WIDOWED~~, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec (Month) 12 (Day), 1874 (Year)

7-AGE, 46 yrs. 3 mos. c ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Messenger at
(b) General nature of industry, business, or establishment in which employed (or employer)..... Custom House

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Parker

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Susie Riley

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret B. Parker

(Address) 11 Cold Spring Ave

15- Filed MAR 17 1921, 191.... ROBERT P. BEAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. Harry Morrison M. D. (Coroner.)

March 17, 1921 (Address) 763 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. — DATE OF BURIAL, March 19 1921

20-UNDERTAKER Jos Joerdens Son — ADDRESS 217 S. Paca

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51959

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 N. Exeter St.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Conway

(a) RESIDENCE. No. 425 N. Exeter St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/11/21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Conway

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Steil

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Emma Conway
(Address) 425 N. Exeter St

15 Filed MAR 17 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16 1921

17 I HEREBY CERTIFY, That I attended deceased from March 12 1921, to March 14 1921, that I last saw her alive on March 14, 1921, and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) A. G. Hornstein, M. D.

3/17, 1921 (Address) 733 Arguith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	March 17 1921
20 UNDERTAKER	ADDRESS
David Eckhart	916 Eastern

N. B.—BIRTH should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51960

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 51960

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 342 E. Twenty-Fifth ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar I. Hoover

(a) RESIDENCE. No. 342 E. Twenty-Fifth ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? --- yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ann Pitt

6 DATE OF BIRTH (month, day, and year): Mar. 10, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Buyer - Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer): Meat Business

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country): Maryland

PARENTS

10 NAME OF FATHER: Frank I. Hoover

11 BIRTHPLACE OF FATHER (city or town): Baltimore
(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Maria Lowry

13 BIRTHPLACE OF MOTHER (city or town): England
(State or country)

14 Informant: Mrs. Mary Ann Hoover
(Address): 342 E. Twenty-Fifth Street

15 Filed MAR 17 1921, 19.... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Mar 16, 1921, that I last saw h.. alive on Mar 15, 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of Liver

about 2 yrs. — mos. — ds. (duration)

CONTRIBUTORY (Secondary): Uremia

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death? Upon Last Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. E. Weems, M. D.

3/17 1921 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	3/19 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

AGE should be carefully supplied. Information should be stated in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-5196 D-5196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 891

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Gibbons Flaherty

(a) RESIDENCE. NO. 1720 Wolfe St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		18		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER J. Gibbons Flaherty

11 BIRTHPLACE OF FATHER (city or town) Ire
(State or country)

12 MAIDEN NAME OF MOTHER Alice M. McGrahon

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant J. G. Flaherty
(Address) 1720 N. Wolfe St

15 Filed MAR 17 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8 1921, to March 15 1921, that I last saw him alive on March 15 1921, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

Empyema (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) Frank C. Thurnes, M. D.

3-17 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	3-18- 1921
20 UNDERTAKER J G Morris	ADDRESS 3000 E. Baltimore

Be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D51962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51962

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West end maternity 19 REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Savage

(Residence in Baltimore: No. ..... St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F.	white	single

6-DATE OF BIRTH, March 16, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. .....mos. .....ds.
If LESS than 1 day, 1 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto., Md

PARENTS.

10-NAME OF FATHER, Louis Savage

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER, Elizabeth Butts

13-BIRTHPLACE OF MOTHER (State or Country), Balto., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed MAR 17 1921, 191.. JOHNS HOPKINS HOSPITAL Burial Permit Issued

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 16, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 16 1921, to Mar 16 1921, that I saw her alive on Mar 16 1921, and that death occurred, on the date stated above, at 5 3/4 p. m.

The CAUSE OF DEATH* was as follows:

Atelectasis
Asphyxia Pallida
.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) C. B. Woodruff M. D.

Mar 17, 1921. (Address) Franklin Square Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
HOPKINS HOSPITAL	MAR 1 1921, 191...
20-UNDERTAKER	ADDRESS
Commissioner of Health.	

25 1963 Mary Kruse HEALTH DEPARTMENT—CITY OF BALTIMORE 25 1963

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST.: 26 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Kruse

(Residence in Baltimore: No. 629 S 4th St 30 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 30 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Geo — Herman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lena Kruse

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kruse

(Address) 629 S 4th

MAR 17 1921 BODEY & BEAUTE

Filed ....., 191.... Burial Permit Clerk

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mch. 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

I
Diabetes

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes Gangrene

Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. Finley M. D.
(Coroner.)

Mch. 16 1921 (Address) 630 Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart Cem.	Mch 18 1921
20-UNDERTAKER Lilly and Zile	ADDRESS 403 S. Arlington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Relliker

D 51964

D51964

HEALTH DEPARTMENT—CITY OF BALTIMORE

105

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home Hosp. ST.: 8 WARD)

2-FULL NAME George Rellicker

(a) RESIDENCE. No. 1834 Rutland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Rellicker

6 DATE OF BIRTH (month, day, and year) Jan. 23-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	115	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jamison McKenzie Evans

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George L. Rellicker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary M. Yoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Clara Rellicker
(Address) 1834 Rutland Ave

15 MAR 17 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

N. B.—WRITE PLAINLY, with ink, and carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to March 15th, 1921, that I last saw h[illegible] alive on " " 1921, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer Perforated

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 14th 21

Was there an autopsy? No

What test confirmed diagnosis

(Signed) W. D. Mobley, M. D.

, 19 (Address) Church Home Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	March 18 1921
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Park Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D51965

HEALTH DEPARTMENT—CITY OF BALTIMORE

29 D51965

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 913 N. Caroline ST.; (7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara M. Disaia

(a) RESIDENCE. No. 913 N Caroline ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Michael Disaia

6 DATE OF BIRTH (month, day, and year): 8.25.88.

7 AGE: Years 33 Months 6 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Geo. F. W. Geschke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Wiegner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Clara Geschke

(Address) 913 N. Caroline

15 Filed MAR 17 1921 ROBERT J. [illegible] Registrar

Burial permit issued by Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 16. 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1921, to March 16, 1921

that I last saw her alive on March 16, 1921,

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 3

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed: Robert L. A. Mezger, M. D.

1921 (Address) 10 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthew	March 25 1921
20 UNDERTAKER	ADDRESS
Wendell Haggerty Son	37 Saint Paul

mation should be carefully supplied. Avoid abbreviations. Write plainly in ink. Do not use lead pencil. Be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D O A K

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 51966

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51966

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Battery ave. ST.; 2d WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Fowler

(a) RESIDENCE. NO. 1518 Battery ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Rachael A. Fowler

6 DATE OF BIRTH (month, day, and year) Mar. 8th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milling

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER John L. Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country) D.C.

12 MAIDEN NAME OF MOTHER Hannah Wenz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Sarah Fowler

(Address) 1518 Battery Ave.

15 Date received MAR 17 1921 ROBERT F. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch. 13, 1921, to Mch 15, 1921, that I last saw him alive on Mch 15, 1921, and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH* was as follows:

Hemaplegia.

2nd

over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. E. Supplee M. D.

, 19 (Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Mar. 18 1921

20 UNDERTAKER E. J. Fanning & Son ADDRESS 1460 Battery Ave.

N. B.—... should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer. Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—6-9-19—H. P. Co.—1000 Bks.

951967 HEALTH DEPARTMENT—CITY OF BALTIMORE 951967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Forbs.

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST. Fort McHenry WARD. Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
47 yrs.	--	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman.

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Registrar (Address) US. PHS. Hosp. #56 Ft. McHenry Md.

15 Filed MAR 17 1921 [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1921, to March 16, 1921, that I last saw him alive on March 16 1921, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of external genitals.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No.

What test confirmed diagnosis? Exam.

(Signed) Thos R. Payne, M. D.

, 19 (Address) US. PHS. Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 1921
20 UNDERTAKER	ADDRESS
Max Levinson	Balto

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51968

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51968

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 79

CITY OF BALTIMORE: (No. 1822 W. Saratoga Street ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta McGinnis

(a) RESIDENCE. No. 1822 W. Saratoga Street ST. 20 WARD. (resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? 60 yrs. 7 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles F. McGinnis

6 DATE OF BIRTH (month, day, and year) August-15-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jas. H. Hogg

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret C. Raborg

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Chas. F. McGinnis (husband)
(Address) 1822 W. Saratoga St.

15 Filed MAR 17 1921 19 [illegible] Registrar
Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1921

17 I HEREBY CERTIFY, That I attended deceased from January, 1918, to March 15, 1921, that I last saw h— alive on March 10, 1921, and that death occurred, on the date stated above, at 5:40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bilateral Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Canal O'Neil, M. D.

3/16, 1921 (Address) 344 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Mar-17-21

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY. PENCIL NOT TO BE USED. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51969 HEALTH DEPARTMENT—CITY OF BALTIMORE D51969

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 Newington Ave ST.: 13 WARD)

2-FULL NAME Mrs Margaret Roberts Howard

(a) RESIDENCE. NO. 800 Newington Ave ST., 13 WARD. Rocks-Harford Co. Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? 52 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of John Carvile Howard

6 DATE OF BIRTH (month, day, and year) About 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ...min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Harford County Maryland

10 NAME OF FATHER Wm J. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hertford Co Md

14 Informant (sister) Miss Mary Roberts (Address) 1116 St Paul St. City

15 Filed MAR 17 1921 19.. Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 16 March 1921

17 I HEREBY CERTIFY, That I attended deceased from 7 Feb, 1921, to 16 March, 1921, that I last saw her alive on 16 March, 1921, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis - Pathateia

(Signed) Nora W Byers, M. D.

. 19 (Address) 749 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Spring Cemy, Hoffd Co Md 3/19/1921

DATE OF BURIAL

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. If impossible to obtain exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51970

CERTIFICATE OF DEATH.

REGISTERED No. 164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Poplar Grove St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Elise Beckman

(a) RESIDENCE. No. 1734 Poplar Grove ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 20 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer) Department Store.

(c) Name of employer Jos. Tutman

9 BIRTHPLACE (city or town) Hildesheim
(State or country) Germany

PARENTS

10 NAME OF FATHER Johann E Spengler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Hildesheim Germany

12 MAIDEN NAME OF MOTHER Lisette Wilerding

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hildesheim Germany

14 Informant Daughter. Mrs. E Lazarus
(Address) 1734 Poplar Grove St

15 Filed MAR 17 1921 19 ROBERT J. KRAUTER Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to Mar 16, 1921, that I last saw her alive on Mar 12, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) U L Tumbleson, M. D.

Mar 16 1921 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mch 18 1921

20 UNDERTAKER Jos R Cook

ADDRESS 1003 Baltimore St

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS should be stated EXACTLY. PHYSICIAN'S name and address should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51971

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) St. Agnes Hospital ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Miriam Houder.

(a) RESIDENCE. NO. 2026 N. Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of L. Louis Houder

6 DATE OF BIRTH (month, day, and year) Aug. 14" 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45 yrs.	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Richard Perrine

11 BIRTHPLACE OF FATHER (city or town) (State or country) " Maryland "

12 MAIDEN NAME OF MOTHER Sarah E. Stansbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " Maryland

14 Informant L. Louis Houder. (Address) 2026 N. Lexington

15 Filed MAR 17 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-15, 1921, to 3-16, 1921, that I last saw h-er alive on 3-16, 1921, and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Chronic Interstitial Nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) W. M. C. Crane, M. D.

(Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ford Lawn Cem	Mar. 18" 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51972

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2617 Guilford Ave. ST. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Barron

(a) RESIDENCE. No. 2617 Guilford Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ========

6 DATE OF BIRTH (month, day, and year) Apr. 15- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos. J. Barron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Hazel R. Donohoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Thos. J. Barron (Address) 2617 Guilford Ave.

15 Filed MAR 17 1921 [illegible] Registrar

Burial Permit Filed

N. B.—WRITE LEGIBLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 17, 1921, to March 16, 1921, that I last saw h[illegible] alive on March 16, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) [illegible] M. D.

3-17, 1921 (Address) 1 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery.	3/18 1921
20 UNDERTAKER	ADDRESS
C.F.Evans & Son-115 W. Mt	Royal Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D51973

REGISTERED NO. 94

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 N. Fulton Ave St. 15 WARD)

2-FULL NAME John Thomas Barber

(a) RESIDENCE. NO. 1715 N. Fulton Ave St. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Minnie Barber.

6 DATE OF BIRTH (month, day, and year) Sept 14-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work real-estate business

(b) General nature of industry, business, or establishment in which employed (or employer) " " " "

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Gordon Barber.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Johnston

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Minnie Barber
(Address) 1715 N. Fulton Ave

MAR 17 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1924

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1924, to March 15, 1924, that I last saw h.im alive on March 15, 1921, and that death occurred, on the date stated above, at 11:50 a. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Septic pyorrhoea.

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Chester Riland, M. D.

3-15, 1921 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 18 1921

20 UNDERTAKER Josiah Syfer ADDRESS 1600 North Howard Ave

N. B.—WRITE PLAINLY, with ink. All items should be supplied. AGE should be carefully supplied. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

The Typhoid was the Primary Cause. No other infection

D51974 Marcelian Williams

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D51974

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1611 Bond Frederick Sr. ST.; Irvington 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Marcelian Williams

(Residence in Baltimore: No. Kaman Md St.; yrs. mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	married

6-DATE OF BIRTH: March (Month) 8th (Day), 1873 (Year)

7-AGE: 48 yrs. — mos. 13 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: John A. Day

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Bennett

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles L. Williams per. Dr. C. L. Lee

(Address) Kaman, Maryland

15- Filed MAR 17 1921 ROBERT B. [illegible] Registrar Clerk
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 16th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23d, 1920, to, March 16th 1921, that I saw h.. alive on March 15th 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of The Heart (Chronic)

unknown (Duration) ..... yrs ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs ..... mos. ..... ds.

(Signed), Charles Lee, M. D. M. D.

March 16, 1921 [Address] 1611 W. Lanvale St.

* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence: Kaman Md

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Friendship Cemetery	Mar. 19, 1921
20-UNDERTAKER	**ADDRESS**
Josiah Syfer	1600 W. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. THE OCCUPATION must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51975 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51975

CERTIFICATE OF DEATH. + 42

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sutkin.

(a) RESIDENCE. NO. Belair, Md. ST., WARD. Belair Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) November 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John T Sutkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mr John Sutkin

(Address) 52 Columbia Ave

MAR 17 1921 Filed ..... 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1920, to March 16, 1921, that I last saw her alive on March 16, 1921, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory, Physical Signs, Operation

(Signed) L. C. Marcus, M. D.

3/16/21 (Address) 4 Wright Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Mch 18th 1921

20 UNDERTAKER John F. Cowan & Son

ADDRESS 401 Hall Pl

—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51976 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51976

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 143 E Cross ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Lawrence

(a) RESIDENCE. NO. 143 E Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Howard Lawrence

11 BIRTHPLACE OF FATHER (city or town) Balto, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Finan

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md.
(State or country)

14 Informant Mrs. Mary Lawrence
(Address) 143 E. Cross St.

15 Filed MAR 17 1921 Robert P. Harrison, Registrar
Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 15, 1921.

that I last saw h alive on March 15, 1921.

and that death occurred, on the date stated above, at 8-30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. M. Wheeler M. D.

3/17, 1921 (Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem, Brookl	Mar. 18 1921

20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

N B.—WRITE PLAINLY, WITH CAPITAL LETTERS. AGE should be stated EXACTLY. PHYSICIANS' information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.51977 HEALTH DEPARTMENT—CITY OF BALTIMORE D 51977

CERTIFICATE OF DEATH.

REGISTERED NO. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 N. Mount ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Gavenkort

(Residence in Baltimore: No. 1135 N. Mount St.; 44 yrs., 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	single

6-DATE OF BIRTH, Jan. (Month) 28 (Day), 1877 (Year)

7-AGE,	If LESS than 1 day,
44 yrs. 1 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper - Housework
(b) General nature of industry, business, or establishment in which employed (or employer): McCauley's Co.

9-BIRTHPLACE, (State or Country), Baltimore - Md.

PARENTS.

10-NAME OF FATHER, Anthony C Gavenkort

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Frances A. Masterman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie Ryan

(Address) 1135 N. Mount St.

15-

Filed....., 191.... Robert P. Harrison, Registrar.

MAR 17 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 3 1921, to March 16 1921, that I saw her alive on March 15 1921, and that death occurred, on the date stated above, at 12.08 a m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis supervening a general Phlebitis and Aortitis with valvular insufficiency

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Aortitis + Exhaustion

(Duration) x yrs. x mos. 15 ds.

(Signed) P. B. Wilson M. D.

3116, 1921. (Address) 1124 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Mar. 19, 1921

20-UNDERTAKER Margaret J. Flynn ADDRESS 1422 Light St.

B.—Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 51978 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 51978

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Forster Ave ST.; 26 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fredericka F. Busse

(Residence in Baltimore: No. 3808 Forster Ave St.; 31 yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, May 11, 1865
(Month) (Day) (Year)

7-AGE, 55 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknon

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Hetta Utsch

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr August Busse

(Address) 3808 Forster Ave

15-

Filed ....., 191.....

Registrar.

MAR 7 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 / 15 / 21, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6 / 1 / 20 191..., to 3 / 15 / 21 191...,
that I saw h.. alive on 3 / 15 / 21 191...,
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma Liver

..... (Duration)...1...yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) J. W. Brosman M. D.

3/16/21, 191... (Address) 819 E Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Mar. 18.., 192.1.
20-UNDERTAKER	ADDRESS
Peter Nicolaus	2546 Eastern Ave

8.—Every item of information should be carefully supplied. AGE should be stated in YEARS and FRACTIONS of a YEAR. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D. 51979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 51979

CERTIFICATE OF DEATH.

1789

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 Forest ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gaetano Lucchese

(Residence in Baltimore: No. 526 Forest st. St.; ..... yrs., 8 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, August (Month) 7 (Day), 1843 (Year)

7-AGE, 78 yrs. 7 mos. 9 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Italy.

PARENTS.

10-NAME OF FATHER, Carmelo Lucchese

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Maria Bucheri

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Domenico Bellistri

(Address) 526 Forest st.

15-

Filed ..... 19.. Robert P. Harrison, Registrar.

MAR 17 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to March 16, 1921, that I saw h[illegible] alive on March 16, 1921, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene R. Parasino M. D.

March 17, 1921. (Address) 2314 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 8 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Italy

19-PLACE OF BURIAL OR REMOVAL, St. Vincent de Paul — DATE OF BURIAL, March 19, 1921

20-UNDERTAKER Denge J. Ruth — ADDRESS 1735 Hoffman

N.B.—Every item of information should be carefully supplied. AGE should be accurately stated. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51980 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51980

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Joseph Hospital 9 79 REGISTERED NO.

CITY OF BALTIMORE (No. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Dorsey

(a) RESIDENCE. NO. 26 Boone St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
abt 90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 0+0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant. Wm. H. Callahan Sr
(Address) 427 E. 37th Street

15 Filed MAR 17 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1921, to Mar 17, 1921, that I last saw him alive on Mar 17, 1921, and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Chas O'Donovan, M. D.

3/17 1921 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (Cash)	DATE OF BURIAL
Evergreen Cem	March 19 24
20 UNDERTAKER	ADDRESS
William Cook	502 E. Monument Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51981 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51981

CERTIFICATE OF DEATH. 28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Harrow

(a) RESIDENCE. No. 894 W. Lombard st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. WITH EXCEPTIONS NOTED, ALL ITEMS should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER J.J.Harrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Crittenden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed MAR 17 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1921, to March 17, 1921.

that I last saw him alive on March 17, 1921.

and that death occurred, on the date stated above, at 1.10 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. Rigney, M. D.

3-17-21. (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Mausoleum | DATE OF BURIAL 12

20 UNDERTAKER William Cook | ADDRESS 502 E. Nath Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.51982 HEALTH DEPARTMENT—CITY OF BALTIMORE D.51982

CERTIFICATE OF DEATH. X 28

1-PLACE OF DEATH U.S. Public Health Hosp. #56. REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 24 WARD) 35a (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Baldock

(a) RESIDENCE. No. US. Public Health Hosp. #56 ST. Fort McHenry WARD Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. ✓ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28 yrs.	-	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter.

(b) General nature of Industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Kaenbrock Registrar. (Address) US. PHS. Hosp. #56 Ft. McHenry Md.

15 Filed MAR 17 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS ... should be stated EXACTLY. PHYSICIAN'S ... mation should be carefully supplied. AGE ... it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that ... on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17 I HEREBY CERTIFY, That I attended deceased from February 11 1921 to March 16 . 1921. that I last saw h... alive on March 16 . 1921., and that death occurred, on the date stated above, at 11'50 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary & far advance & active.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ----

Was there an autopsy? No

What test confirmed diagnosis? Exam. & Lab. report.

(Signed) Thomas B. Payne M. D. Senior Surgeon (R)

, 19 (Address) US. PHS. Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lynchburg Va	Mar 17 1921
20 UNDERTAKER	ADDRESS 1127 E
A. Leinzer & Bro	Balto. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stat.—6-9-19—H. P. Co.—1000 Bks.

D51983 HEALTH DEPARTMENT—CITY OF BALTIMORE D51983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 14 102

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1555 Pinestreet ST.: WARD)

2-FULL NAME Rena Elizabeth Bailey

(a) RESIDENCE. No. 555 Pinestreet ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A Bailey

6 DATE OF BIRTH (month, day, and year) Mar 15 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hampton
(State or country) Virginia

PARENTS

10 NAME OF FATHER Mr. Wright

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen Tobin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant James A Bailey
(Address) 555 Pinestreet

15 FILED MAR 18 1921 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 28th, 1921, to March 16, 1921, that I last saw h.. alive on March 16 - 1921, and that death occurred, on the date stated above, at 6-15 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer
(Perforated)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock following perforated gastric ulcer (duration) 7 hours yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray Examination

(Signed) Burwell Large, M. D.

3-17 1921 (Address) 711 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mch. 19 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 1417 Usher St

D51984 HEALTH DEPARTMENT—CITY OF BALTIMORE D51984

Glebus

CERTIFICATE OF DEATH.

157

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Balt & Pyrr sts ST.: 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Glebus

(Residence in Baltimore: No. ~~D~~ 646 W Lombard St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Don't Know (Month) (Day) (Year)

7-AGE: 41 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Don't Know

11-BIRTHPLACE OF FATHER (State or Country): Don't Know

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (State or Country): Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Glebus

(Address) 646 W. Lombard St.

15- Filed MAR 18 1921, 191.. ROBERT F. [illegible] Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ topsy or inquiry.) find that said deceased came to the death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hanged himself

(Duration) a few minutes

CONTRIBUTORY (Secondary) Suicide

(Duration) a few minutes

(Signed) H. H. Jonas M. D. (Coroner.)

3.17, 1921 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	March 19, 1921
20-UNDERTAKER	ADDRESS
John Grebliunas	425 S. Poca St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51985

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51985

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 S Poppleton ST. 21 WARD)

2-FULL NAME Albert Heimerdinger

(a) RESIDENCE. NO. 406 S Poppleton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker 014

(b) General nature of industry, business, or establishment in which employed (or employer) wood worker

(c) Name of employer United Elect. Ry. Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm. Heimerdinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Kate Cavanaugh
(Address) 406 S Poppleton

15 Filed MAR 18 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1920, to Mar 16, 1921, that I last saw h... alive on Mar 14, 1921, and that death occurred, on the date stated above, at 3-P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) C F Buxton, M. D.

3/16 1921 (Address) 302 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: March 19 1921

20 UNDERTAKER: John J Cowan & Son

ADDRESS: 901 Hollins St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 139 N. Kenwood Ave ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. O'Rourke

(a) RESIDENCE. NO. 139 N. Kenwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma W. O'Rourke

6 DATE OF BIRTH (month, day, and year) Nov 21. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	64	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter Carrier 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S.

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Luke B Rourke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Emma W. O'Rourke
(Address) 139 N. Kenwood Ave

15 Filed MAR 18 1921 ROBERT I. [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1921

17 I HEREBY CERTIFY, That I attended deceased from June 8, 19 20, to Mar 15, 19 21,
that I last saw h. alive on Mar 17, 19 21,
and that death occurred, on the date stated above, at 12 50 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteo - Sclerosis.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. H. Mayo Jr. M. D.

3/16 19 21 (Address) 1138 E. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	March 18 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2178 Pres.

N. B.—WHITE PEOPLE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form—6-9-19—H. P. Co.—1000 Blks.

D51987

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51987

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 D. Fremont ave ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Lizzie Holmes

(a) RESIDENCE. No. 1013 D. Fremont ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. & mos. & ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with pen and ink. PHYSICIANS should state AGE should be stated EXACTLY. mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeremiah Holmes

6 DATE OF BIRTH (month, day, and year) Unknown 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo. Grooms

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah E. Whelen

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant P. W. Brown
(Address) 108 N Monte St

15 Filed MAR 18 1921 19.. ROBERT J. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 16, 1921, to Mar 17, 1921, that I last saw h.. alive on Mar 16, 1921, and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Jno A. Tompkins, M. D.

3/17/1921 (Address) 1019 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	March 19 1921
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	108 N Monte St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 5 1988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 5 1988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 Franklin Tee ST.; 9 WARD)

REGISTERED NO. 64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ann McCulloh

(a) RESIDENCE. No. 511 Franklin Tee ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Richard McCulloh

6 DATE OF BIRTH (month, day, and year) Oct 19th 1829

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	91	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore City
(State or country) Md

PARENTS

10 NAME OF FATHER Henry Lightner

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country) Md

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Don't Know
(State or country)

14 Informant Mrs Amanda J. Bohlenstein
(Address) 511 Franklin Tee

15 Filed MAR 18 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1921, to March 16, 1921, that I last saw her alive on March 16, 1921, and that death occurred, on the date stated above, at 530 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Chronic Gastritis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm Pearce, M. D.

3-16, 1921 (Address) 5 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 18th 1921
20 UNDERTAKER	ADDRESS
Geo. Weber & Son 2503	Edmondson Ave

N. B.—WRITE PLAINLY, with pen and ink. All items should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51989 HEALTH DEPARTMENT—CITY OF BALTIMORE D51989

CERTIFICATE OF DEATH. 186

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balt City Jail St. 10 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Louis

(a) RESIDENCE No..... St., ... Ward. Richmond Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1mo yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) City Jail

15 Filed MAR 18 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1921

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 18, 1921, that I last saw h[illegible] alive on March 18, 1921, and that death occurred, on the date stated above, at 2052 p. m.

The CAUSE OF DEATH* was as follows:

Hanging by neck

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dislocation Cervical Vertebrae (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J. Powers M. D.

, 19 (Address) 921 N. Chas. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	March 1921
20 UNDERTAKER	ADDRESS
Wm. Uhler & Son	1939 N. Rose St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51990

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51990

CERTIFICATE OF DEATH.

186

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Jail ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Davis

(a) RESIDENCE. NO. 204 Albemarle ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Usl yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
M	C	single

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Jail
(Address)

15 Filed MAR 18 1921 19.. [illegible] Registrar

Burial Permit Oiord

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 18, 1921, to Mch 18, 1921, that I last saw him alive on Mch 18, 1921, and that death occurred, on the date stated above, at 9.05a m.

The CAUSE OF DEATH* was as follows:

Hanging by neck

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Dislocation cervical vertebrae (duration) 5 minutes yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) 621 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	Mch 18 1921

20 UNDERTAKER ADDRESS

Wm - Wm M S Finch 1835 N Pat

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE date of death must be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51991

CERTIFICATE OF DEATH.

6 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N Lakewood ave ST.: 6 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Wrightson

(a) RESIDENCE. No. 411 N Lakewood ave WARD.

(Usual place of abode) (If nonresident give City or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. life mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25 1880

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Packing 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Wrightson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Apple

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Samuel Wrightson (Address) 411 N Lakewood ave

15 FILED MAR 18 1921 ROBERT J. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to March 16, 1921, that I last saw her alive on March 14, 1921, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Toxemia - Edema of Lungs (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Schmit M. D.

3/17 1924 (Address) 701 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 19 1921

20 UNDERTAKER Chas C. Miller ADDRESS 2334 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51992 HEALTH DEPARTMENT—CITY OF BALTIMORE D51992

CERTIFICATE OF DEATH. 103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 N. Carolina ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Evans, Sr.

(a) RESIDENCE. NO. 1339 N Carolina ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Catherine C. Evans

6 DATE OF BIRTH (month, day, and year) Oct 13-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Funeral Director

(b) General nature of industry, business, or establishment in which employed (or employer) Chas F. Evans & Son

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER Chas Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Ellen Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Geo T. Evans
(Address) ~~1705~~ 3128 Guilford Ave

15 Mar MAR 18 1921 ROBERT A KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 14, 1921, to Mar. 16, 1921, that I last saw him alive on Mar. 16, 1921, and that death occurred, on the date stated above, at 8:12 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilitation (acute)

(duration) Immediate yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Benj. D. Hayden M. D.

3/18. 1921 (Address) 216 N. Carolina st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	3/19 1921
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	1180 Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51993

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51993

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. Division ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Frank A Payne

(a) RESIDENCE. No. 2121 W. Mulberry ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Frank Payne

6 DATE OF BIRTH (month, day, and year) Apr. 17-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	11	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Thomas Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Mary Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Lucie Payne (Address) 2121 Mulberry St

15 Filed MAR 18 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 7, 1921, to Mch 17, 1921, that I last saw him alive on Mch 17, 1921, and that death occurred, on the date stated above, at 8.10 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Hypertypreidism

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Partial Thyroidectomy 10 hours

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Mch. 17-21

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. G. Shackelford, M. D.

, 19 Address Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union Bridge - Carroll Co	March 9 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D51994

CERTIFICATE OF DEATH.

30

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 720 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles ~~Hamilton~~ Elmer Mantlin, Jr.

(a) RESIDENCE. No. 2133 Pennsylvania Ave Baltimore Md WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	1			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Chas. E. Mantlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary F. Donnelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Johns Hopkins Hospital Records (Address)

15 MAR 18 1921 ROBERT F. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to March 17, 1921, that I last saw him alive on March 17, 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lumbar puncture

(Signed) W. Warren, M. D.

3-17. 1921 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Mar. 21 1921.
20 UNDERTAKER	ADDRESS
F. M. Offutt, Jr.	224 S. Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lituviuska

D51995

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N Luzerne av ST.: ..... WARD)

2-FULL NAME Mary Lituvinska

(a) RESIDENCE. NO. 223 N Luzerne av ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: no work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Sebestyan Pistnor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Maryanna unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Rytta Stolz

(Address) 223 N Luzerne [illegible]

15 Filed MAR 18 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 30 20 19.. to Mch 17 19 21.

that I last saw h[illegible] alive on Mch. 15 1921.

and that death occurred, on the date stated above, at 9 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) Ger. Heller M. D.

3.18. 19 21 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	March 19 1921

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 51996

+176

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Brydon.

(a) RESIDENCE. No. 23 College Av ST., Danville Va. WARD. Danville Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. seventeen mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 29 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Wm Brydon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret McLaren

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) J. Hopkins Hospital Records

15 Filed MAR 18 1921 19.....

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to March 17, 1921, that I last saw h alive on March 17, 1921, and that death occurred, on the date stated above, at 9.00 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis hypertrophy.

Senility

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary embolus.

(duration) 5 days ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/4/21

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H. A. Kelly, M. D.

3-8, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Danville Va	March 18 21

20 UNDERTAKER H E Wyles & Son ADDRESS 1 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 51997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51997

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Smallwood

(a) RESIDENCE. No. 245 S. Dallas st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Smallwood

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Wm. Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Annie ??

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records

(Address) M.T.H.

15 Filed MAR 18 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to March 16, 1921, that I last saw h.. im alive on March 16, 1921, and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. D. Digney. M. D.

3-17-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.,	Mar 20 1921

20 UNDERTAKER Harry A. Vodery ADDRESS 1726 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERM... RECORD. ... should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

State.—6-9-19—H. P. Co.—1000 Bks.

D 51998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 51998

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Eden St ST.; 10 WARD)

2-FULL NAME Christoph. Mueller

(a) RESIDENCE. No. 917 N. Eden St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21st 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rebella Mueller
(Address) 917 N. Eden st

15 MAR 18 1921 [illegible] Registrar
Burial Permit Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to March 17, 1921.

that I last saw him alive on March 16, 1921.

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Sandrock, M. D.

Mar. 17, 1921 (Address) 1242 N. Bradway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	March 21 1921
20 UNDERTAKER	ADDRESS
Frank D. Fink	916 N. Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D51999 HEALTH DEPARTMENT—CITY OF BALTIMORE D51999

CERTIFICATE OF DEATH.

Wilbrook 81

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. D 3706 Chestnut Rd (St.) 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Sahm.

(a) RESIDENCE. No. 3706 Chestnut St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single, Married,~~ Widowed, or Divorced (write the word): widowed.

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Mary A. Sahm

6 DATE OF BIRTH (month, day, and year): Jan 27, 1834

7 AGE: Years 87 | Months 1 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Robt A. Sahm
(Address) 3706 Chestnut Rd

15 Filed MAR 18 1921 Robert F. Klauber Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar- 8, 19 24, to Mar. 17, 19 24, that I last saw him alive on Mar 15, 19 24, and that death occurred, on the date stated above, at 5 7:30 P m.

The CAUSE OF DEATH* was as follows: Senility.— Arteriosclerosis (no other demonstrable lesion)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Stanley Cole, M. D.

3/18 1921 (Address) 2702 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem Frederick Rd

DATE OF BURIAL: Mar 19 1921

20 UNDERTAKER: Bertram Bros

ADDRESS 1723 W Fay Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on b

should state
Exact statement of OCCUPA-
s on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

52000 D. 52000

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5416 Park Heights Ave. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Walter Broughton

(a) RESIDENCE. NO. 5416 Park Heights Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Broughton

6 DATE OF BIRTH (month, day, and year) Mch. 16" 1869

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	0	1	

8 OCCUPATION OF DECEASED 073

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) B and O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hope Valley R. I.

PARENTS

10 NAME OF FATHER James Broughton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Martha Greenausch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Mary E. Broughton

(Address) 315 Chestnut Springfield, Mass

15 Filed MAR 18 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 17" 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 3, 1921, to Mch 17, 1921, that I last saw h in alive on Mch 17, 1921, and that death occurred, on the date stated above, at 12.30 Noon

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Double)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Shop.

Did an operation precede death? No Date of

Was there an autopsy? No Clinical.

What test confirmed diagnosis?

(Signed) H. Taylor M.D. M. D.

19 Mch. 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Springfield Mass	Mch 18 1921
20 UNDERTAKER	ADDRESS
J. R. Cook	1031 Baltic St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE ... it may be properly classified. Exact statement of OCCUPA... CAUSE OF DEATH in plain terms, so that ... on back of certificates. See instructions ... TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52001 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52001

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Gross

(a) RESIDENCE. NO. ~~Unknown~~ 612 Calendar ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ~~1845~~ Nov 25 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	~~73~~ 72	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ~~Unknown~~ Peter Lauinger

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER ~~Unknown~~ Catherine Schwind

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed MAR 18 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1921 to March 17, 1921

that I last saw her alive on March 17, 1921

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(No cerebral hemorrhage)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) [illegible] Hoffman, M. D.

3/17/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Cathedral Cem. Mar 19 1921

20 UNDERTAKER N. J. Dickneider Son ADDRESS N Y Pa

D.52002 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1623 Hanover St. ST.: 23 WARD) 170 REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Imhoff.

(Residence in Baltimore: No. 1623 Hanover St. St.: 10 yrs., 16 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White.	Married.

6-DATE OF BIRTH, February 2nd. 1881., 1 (Month) (Day) (Year)

7-AGE, 40 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Berkley Co. W. Va.

PARENTS.

10-NAME OF FATHER, Winfield S. Myers.

11-BIRTHPLACE OF FATHER (State or Country), West Virginia.

12-MAIDEN NAME OF MOTHER Mary Fellers.

13-BIRTHPLACE OF MOTHER (State or Country), West Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George N. Imhoff. (husband)

(Address) 1623 Hanover St.

15- Filed MAR 18 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 16th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Bernhard M. D. (Coroner)

March 17, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Martinsburg W. Va	Mar 19, 19....
20-UNDERTAKER	ADDRESS
E J Fanning	1460 Battery ave

Spec.—8-24-14—M. & T.—2000 Bks.

D.52003 HEALTH DEPARTMENT—CITY OF BALTIMORE D52003

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1043 Hanover St. 23 Ward) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C Bell

(Residence in Baltimore: No. 1043 Hanover St.; 63 yrs., mos. ds.)

WRITE PLAINLY, with UNFADING INK—THIS IS PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, Mar 13, 1857 (Month) (Day) (Year)

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas W Bell

(Address) 1417 Johnson St

15-

Filed MAR 9 1921, 191 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 16, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 15 1921, to Mar 16 1921, that I saw h alive on Mar 16 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 2 ds.

(Signed) R E Campbell M. D.

Mar 17 1921 (Address) 1644 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westernview — DATE OF BURIAL, Mar 19 1921

20-UNDERTAKER Robt J Turner Jr — ADDRESS 1142 N Pine

Thomas J. (Conroy)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52004

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 S Washington ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos J Conroy

(a) RESIDENCE. NO. 413 S Wash't ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 4 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Anna Conroy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Anna Conroy
(Address) 413 S Washington St

15 Filed MAR 18 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to March 17, 1921,

that I last saw h— alive on " ", 19—,

and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY —
(Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Wentzen M. D.

3/17, 1921 (Address) 413 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 19 1921
20 UNDERTAKER Capt J Kemper & Son	ADDRESS 1818 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement may be properly classified. CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

(Pearl Herman)

D.52005

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52005

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 E. ... ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Pearl Herman

(a) RESIDENCE. No. 3038 Greenmount ave. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. E. L. Herman

6 DATE OF BIRTH (month, day, and year) June 6 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co. Md.

PARENTS

10 NAME OF FATHER John Crouch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant E. Clinton Herman

(Address) 3038 Greenmount Ave

15 Filed MAR 18 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 19 21

17

I HEREBY CERTIFY, That I attended deceased from 3/15 19 21, to 3/15 19 21,

that I last saw h alive on 3/15 19 21,

and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

Tbc Pulmonary

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Lindsay, M. D.

3/21, 19 21 (Address) 1102 E. ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 21 21
20 UNDERTAKER A. S. Marshall	ADDRESS 3539 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52006

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52006

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 E. Preston St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Madison

(a) RESIDENCE. NO. 206 E. Preston St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced (write the word)~~
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 27 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Advertising Business

(b) General natore of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bloomfield N.J.

PARENTS

10 NAME OF FATHER Wm. H. Madison

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Mary A. Macconnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont

14 Informant Frank E. Madison

(Address) 103 Thomas St Bloomfield N.J.

15 Filed 19 Robert P. Harrison, Registrar

MAR 18 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 16, 1921, that I last saw him alive on March 16, 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Cold

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? In mine

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm Pearce, M. D.

3-15-21 19 (Address) 1 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bloomfield N.J.	Mar 19 1921
20 UNDERTAKER	ADDRESS
Jos Sochalers Son	217 S. Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52007

CERTIFICATE OF DEATH.

64

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital WARD)

2-FULL NAME Mrs Anna Steinert

(a) RESIDENCE. No. St Josephs Home ST. 15 years WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otto Steinert

6 DATE OF BIRTH (month, day, and year) Aug 25th 1841

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Ewald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Steinert

(Address) 232 E Biddle St

MAR 18 1921

Robert P. Harrison, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/1921

17

I HEREBY CERTIFY, That I attended deceased from March 10 1921, to March 17, 1921, that I last saw her alive on March 17, 1921, and that death occurred, on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) mos. ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) Dr. E. C. Donovan, M. D.

'19 (Address) 5 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Mar 21 1921
20 UNDERTAKER Leo G. Cook	ADDRESS North Gaywood

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.52008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52008

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 S. Bethel St. ST.; V WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Janina Lowinska

(Residence in Baltimore: No. 721 S. Bethel St. St.; ..... yrs., 6 mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ~~Sept.~~ Aug. 15, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 6 mos. 3 ds. | If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... " "

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Lowinski

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Johanna Zajac

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lowinski

(Address) 721 S. Bethel St.

15-

MAR 18 1921

Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 18, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 2 1921, to March 18 1921, that I saw h.. alive on March 18 1921, and that death occurred, on the date stated above, at 7:30 ~~P~~ A.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration) ..... yrs. ca 14 mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Lowinski M. D.

3/18, 1921. (Address) 2431 Fait.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary | DATE OF BURIAL, March 21, 1921.

20-UNDERTAKER Wm. Falkowski | ADDRESS Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52009

64

D.52009

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Painters Ct ST.; 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Parker

(a) RESIDENCE. No. 14 Painters Ct ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About June 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Isaac Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaretta Parker
(Address) 14 Painters Ct

15 Filed MAR 19 1921, 19 Robert F. Harris Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 1, 19 13, to March 17, 19 21,
that I last saw h. 17 alive on March 21,
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Cerebral Apoplexy
+ Paralysis (duration) yrs. 8 mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) W. O. Burns, M. D.
March 18-21 19 (Address) 2218 Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	March 19 1921
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	1735 Eastlend

MARYLAND—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52010

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 43 S. Arlington ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence E. Mathews

(a) RESIDENCE. No. 43 S. Arlington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 1. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jas. R. C. Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester Co. Md

12 MAIDEN NAME OF MOTHER Lottie S. Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Manchester Co. Md

14 Informant Jas Luther Mathews
(Address) 43 S. Arlington.

15 Filed MAR 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 13, 1921, to Mar 18, 1921, that I last saw him alive on Mar. 17, 1921, and that death occurred, on the date stated above, at 12.20 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Lumbago

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm. H. Seabury, M. D.

3/18 1921 (Address) 638 Fort

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Mar 19th 1921
20 UNDERTAKER	ADDRESS
H. Fields	1200 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.52011 D.52011

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 575 Greenmillow ST.: 17 WARD)

2-FULL NAME Mrs. Watson

(a) RESIDENCE. NO. 575 Greenmillow ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Last June 15 84

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant David Carlson

(Address) 916 Pa ave

15 Filed MAR 19 1921, 19 Robert F Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 12, 1921, to Mar 16, 1921, that I last saw he alive on Mar 16, 1921, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Hamilton Wasson, M. D.

March 19, 1921 (Address) 1005 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn by

DATE OF BURIAL March 1921

20 UNDERTAKER David Carlson

ADDRESS 916 Pa ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52012

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH #

CITY OF BALTIMORE: (No. 605 Brune ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie or Sarah Fletcher.

(a) RESIDENCE. No. 605 N Brune ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josiah Fletcher

6 DATE OF BIRTH (month, day, and year) Dec 27 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Former Md.

12 MAIDEN NAME OF MOTHER Sarah M Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Sarah M Green

(Address) 615 N Brune St.

15 MAR 19 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 15 1921, to Mar 19 1921, that I last saw h.er alive on Mar 19 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Ulcer of cervix ? suspected T. B. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical.

3/18. 1921 (Signed) Bernard J Fennell M. D.

(Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	March 21 1921
20 UNDERTAKER David Easton	ADDRESS 416 6a ave

MAR 19 1921

GRAVE RECORD.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. B. Co.—1000 Bks.

D.52013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52013

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 Oakley ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Grann-

(a) RESIDENCE. No. 2009 Oakley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Baby-

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-11-21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER George Grann

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Loretta Fortunan

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mrs. Walter Grann
(Address) 2009 Oakley-

15 Filed ....., 19.... Robert F. Leppien, Registrar
MAR 1 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18- 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-17- 10 Pm, 1921, to 3-18 11 Am, 1921, that I last saw h.r alive on 3-17- 11 Pm, 1921, and that death occurred, on the date stated above, at 3 am m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchial Bilious Septicemia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. V. Victor Richards M. D.

, 19 (Address) 2918 Brighton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	3-19- 1921
20 UNDERTAKER E & J. Hasle. Benj. Harley	ADDRESS 115 W. West St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52014 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52014

CERTIFICATE OF DEATH.

REGISTERED NO. 579

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1342 Presstman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Green

(a) RESIDENCE. No. 1342 Presstman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Widowed

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Jane Green

6 DATE OF BIRTH (month, day, and year) Apr 26, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: A. A. Co.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Charles H. Green
(Address): 723 School St

15 MAR 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1921, to Mar 17, 1921, that I last saw h[im] alive on Mar 16, 1921, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. William Frey, M. D.

Mar 19 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis	Mar 20 1921
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 N. Carey

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52015 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52015

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Brunt St. 14 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Combs

(a) RESIDENCE. No. 1413 Brunt St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8-1921

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Combs

11 BIRTHPLACE OF FATHER (city or town) Richmond
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Stella Sullivan

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) District Columbia

14 Informant Stella Combs
(Address) 1413 Brunt

15 Filed MAR 9 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to March 16, 1921, that I last saw HER alive on March 16, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Syphilis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

3 17, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar. 19 1921
20 UNDERTAKER	ADDRESS
Edw. Ruggold	1463 Carey

MARGIN RESERVED FOR BINDING.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 52016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52016

CERTIFICATE OF DEATH.

150

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 Mosher ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Smith

(a) RESIDENCE. NO. 624 Mosher ST., WARD.

(Usual place of abode) (if nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 16/21

7 AGE	Years	Months	Days	If LESS than 1 day, 8 hrs. or ..... min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie Jackson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Frank Smith (Address) 624 Mosher St.

15 Filed MAR 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1921

17 I HEREBY CERTIFY, That I attended deceased from 8.40 pm 3/16/21, to 12 N. 3/17/, 19 21, that I last saw h.. alive on March 17, 19 21, and that death occurred, on the date stated above, at 12 N.—

The CAUSE OF DEATH* was as follows:

Patient Foramen Ovale

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? 150

(Signed) Edward J. Wheatley, M. D.

3/17/1921 (Address) 1230 Dr. Inst Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar 19 1921
20 UNDERTAKER	ADDRESS
Edw. Quiggold	1463 Carey St

MARGIN RESERVED FOR FILING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.52017 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.52017

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 172

CITY OF BALTIMORE (No. Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George D. Rose.

(Residence in Baltimore: No. 708 n Collington ave St.; 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: July (Month) 13 (Day), 1845 (Year)

7-AGE: 75 yrs. 7 mos. 15 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ch. S. Driver
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country): Va.

PARENTS.

10-NAME OF FATHER: James Rose

11-BIRTHPLACE OF FATHER (State or Country): Va

12-MAIDEN NAME OF MOTHER: Mary A. Bailey

13-BIRTHPLACE OF MOTHER (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Louisa Rose

(Address): 708 N. Collington

15- Filed MAR 19 1921, 191.... Robert P. Harrison, Registrar.
Chief Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Mar (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism fell ff

Dec'd (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. Engler M. D.
(Coroner)

3-18, 1921 (Address) 1739 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western — DATE OF BURIAL: Mch 21, 1921

20-UNDERTAKER: Zirkler & Zirkler — ADDRESS 1739 Eager

Spec.—8-24-14—M. & T.—2000 Blks.

D.52018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52018

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Moore

(Residence in Baltimore: No. 701 N. Fulton Av St.; 20 yrs., mos. ds.)

WRITE PLAINLY, WITH CARE. PHYSICIAN is supplied. AGE should be stated EXACTLY. INFORMANT'S Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Oct (Month) 23 (Day), 1858 (Year)

7-AGE, 62 yrs. 4 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Patrolman
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 0 61

9-BIRTHPLACE, (State or Country), Kingsville, Balto. Co. Md

PARENTS.

10-NAME OF FATHER, Alex. Moore

11-BIRTHPLACE OF FATHER (State or Country), Harford Co., Md

12-MAIDEN NAME OF MOTHER Mary A. Schaffer

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna L. Schubert

(Address) 632 N. Washington St.

15-

Filed ....., 191.. Registrar.

MAR 19 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 1921, to Mar 18 1921, that I saw h/m alive on Mar 18 1921, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) L. Ginsburg M. D.

Mar 18, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Kingsville-St Johns

DATE OF BURIAL, Mch 21, 1921

20-UNDERTAKER Zuckler & Zuckler

ADDRESS 1739 Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

14665
D. 52019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52019

CERTIFICATE OF DEATH.

X 137

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Fichet

(a) RESIDENCE. No. 14 Arrowship 2d Dundalk 2nd WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. unknown mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced (or) WIFE of Wm E. Fichet

6 DATE OF BIRTH (month, day, and year) Nov 10. 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Ronspies

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed MAR 19 1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 5 1921, to Mar. 17 1921, that I last saw h 4 alive on Mar 17 1921, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Dundalk Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture.

(Signed) H. K. Mason, M. D.

3-17. 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	March 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

LAIN: ... UNLESS WRITING INK— ... on should be ... fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state SE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.52020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52020

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 422 S. Robinson ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Rodenberg

(a) RESIDENCE. No. 422 S. Robinson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Frederick Rodenberg.

6 DATE OF BIRTH (month, day, and year) Feb 22 - 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	-	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in whirh employed (or employer) housewife 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or rountry) Germany

PARENTS

10 NAME OF FATHER Balzar Hegei

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Staach

13 BIRTHPLACE OF MOTHER (city or town) (State or rountry) Germany

14 Informant Frederick Rodenberg

(Address) 422 S. Robinson St.

15 Filed MAR 19 1921 19 Robert P. Harrison Registrar

Burial Permit Blank.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17 I HEREBY CERTIFY, That I attended dereased from October, 1920, to March 16, 1921, that I last saw h.. alive on March 15, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Syncope

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Health Dept.

(Signed) [illegible], M. D.

Mch 19 1921 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	Mch 19 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 E. Eager St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52021

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 415 N Parrish ST.: 19 WARD)

2-FULL NAME Maria Holmes

(a) RESIDENCE. No. 415 N Parrish ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col'd	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)	Years	Months	Days	If LESS than 1 day, hrs. or min.
Unknown	1851			
7 AGE	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Essex Co Va

9 BIRTHPLACE (city or town) (State or country) Essex Co Va

PARENTS

10 NAME OF FATHER William Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co Va

12 MAIDEN NAME OF MOTHER Matilda Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co Va

14 Informant (Address) F. W. Holmes 415 N Parrish

15 Filed MAR 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1920, to March 17, 1921, that I last saw h alive on March 16, 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Bronchitis

(duration) Uncertain yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Moorehead, M. D.

March 17 1921 (Address) 935 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Essex Co Va Bowlesmark — DATE OF BURIAL: March 20 1921

20 UNDERTAKER: John H Owens — ADDRESS: 538 Dolphin

N. B.—WRITE PLAINLY. ANY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52022 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D.52022

CERTIFICATE OF DEATH. 61

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3702 Elm Ave. St.: 13 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy Emory Markey

(a) RESIDENCE. No. 3702 Elm Ave. St., 13 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 27-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER D. Emory Markey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Sarah E. Handy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va.

14 Informant D. Emory Markey
(Address) 3702 Elm Ave.

15 Filed MAR 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 10th, 1921, to Mar 17, 1921, that I last saw him alive on Mar 17, 1921, and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis (Streptococcus)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Respiratory Failure.

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Lumbar puncture

(Signed) [illegible] M. D.

3/18, 1921 (Address) 846 W 36 or 87.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Mary's (Hampden) March 19 1921

UNDERTAKER Horace Burgee & Son ADDRESS 3631 Falls Rd

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52023 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52023

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary T Bowen

(a) RESIDENCE. No. Owings Mills Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. 4 ds. How long in U. S., If of foreign birth? 30 yrs. — mos. — ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas H. Bowen

6 DATE OF BIRTH (month, day, and year) June 16-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hsew wife

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) ? Ireland

PARENTS

10 NAME OF FATHER John Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Ireland.

12 MAIDEN NAME OF MOTHER Anna McHenry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Ireland.

14 Informant Patient (Mary T Bowen.
(Address) Owings Mills Md.

15 Filed MAR 9 1921 Robert F. Garrison, Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to March 17, 1921, that I last saw her alive on March 17th, 1921, and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease
Mitral Stenosis and Regurgitation

7 (duration) yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

7 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. Morris Reese, M. D.

3-17, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Druid Ridge March 21 1921

UNDERTAKER — ADDRESS

Horace Burgee & Son 3631 Falls Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52024

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52024

CERTIFICATE OF DEATH.

1921

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 S. Linwood av ST.: 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Christopher

(a) RESIDENCE. No. 613 S. Linwood Ave ST., 1st WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Chamberlain

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Upon wrecks

(b) General nature of industry, business, or establishment in which employed (or employer) Copper works

(c) Name of employer Balto Copper Smelting & Rolling Mills Baltimore Md

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Angelo B. Christopher

11 BIRTHPLACE OF FATHER (city or town) Lucca (State or country) Italy

12 MAIDEN NAME OF MOTHER Sarah Turner

13 BIRTHPLACE OF MOTHER (city or town) Bath (State or country) England

14 Informant Mrs. Nellie P. Phillips

(Address) 613 S. Linwood Ave

15 Filed Robert P. Harrison, Registrar

MAR 19 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 14, 1921, to Mar 17, 1921,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. E. Kline, M. D.

Mar 19, 1921 (Address) 210 Courtland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	March 20 1921
20 UNDERTAKER	ADDRESS
Lilly & Fish	403 S. Wolfe

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

146908
D. 52025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52025

CERTIFICATE OF DEATH.

REGISTERED NO. 30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Burton

(a) RESIDENCE. No. 3439 E. Lombard St ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. H. Hospital Records
(Address)

15 Filed MAR 19 1921 Robert L. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1921

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1921, to March 18, 1921, that I last saw him alive on March 18, 1921, and that death occurred, on the date stated above, at 7 40 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) — yrs. — mos. 17 ds.

CONTRIBUTORY (Secondary) —

— (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) Robert L. Harrison, M. D.

3. 9. 1921 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	March 19 1921
20 UNDERTAKER	ADDRESS
Lilly & Zile	403 S. W. Pkwy.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 52026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52026

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 North Stricker ST. 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles S Wilcoy

(Residence in Baltimore: No. 224 North Stricker St.: 2 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Aug 8, 1846
(Month) (Day) (Year)

7-AGE, 75 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): Do

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Wilcoy

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie E. Wilcoy

(Address) 224 North Stricker St

15-

Filed ....., 191.....

Robert P. Garrison, Registrar.
Burial Permit Clerk

MAR 19 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191.....,
that I saw h.. alive on March 17 1921,
and that death occurred, on the date stated above, at 12 15 m.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Dr. J. Thomas Nelson M. D.

March 19..., 1921. (Address) 1001 N. Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mount View Hanover Co. | DATE OF BURIAL, March 21 1921

20-UNDERTAKER Easton Sons | ADDRESS Edmondson Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK— IS A PERMANENT RECORD.
Every item of information should be carefully supplied. ...ld be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE ...be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52027 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52027

CERTIFICATE OF DEATH. 137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital WARD) 20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sophia Flaig

(a) RESIDENCE. NO. 3602 Frederick Ave WARD. 20

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. A. Flaig

6 DATE OF BIRTH (month, day, and year) Aug 31 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adolph Wiggan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Millie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs. A. Flaig

(Address) 3602 Fred. Ave

15 Filed MAR 19 1921 19 Robert P. Harrison, Registrar

Burial Permit Given

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 19 21

17 I HEREBY CERTIFY, That I attended deceased from 3/8, 19 21, to 3/17, 19 21, that I last saw h[illegible] alive on 3/17, 19 21, and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows: Streptococcus Peritonitis

Autopsy

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Fatty myocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-14-21

Was there an autopsy? No

What test confirmed diagnosis? Culture

(Signed) W. McKelvey, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 21 19 21
20 UNDERTAKER	ADDRESS
Geo. A. Schwab & Bro	310 Cath. Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52028 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52028

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1156 Scott St ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Heider

(a) RESIDENCE. NO. 1156 Scott St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Heider

6 DATE OF BIRTH (month, day, and year) Feb. 16-1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 31

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Geo Carrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn

12 MAIDEN NAME OF MOTHER Mary Jane Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.S. A

14 Informant Henry Heider (Address) 1156 Scott St

15 Filed 19 Registrar

MAR 19 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 1921

17 I HEREBY CERTIFY, That I attended deceased from 1918, 19, to, 19 21, that I last saw h[illegible] alive on 2/16/21, 19, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Stein, M. D.

3/19, 1921 (Address) 1229 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Mar 21 1921
20 UNDERTAKER	ADDRESS
Geo Lohmeyer & Bro	2101 Eutaw Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52029

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52029

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto Ave St Helena ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel J. Bond.

(a) RESIDENCE. NO. Balto Ave St Helena ST. 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Louisa Bond.

6 DATE OF BIRTH (month, day, and year) Feb 11th 1837.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boat House 66

(b) General nature of industry, business, or establishment in which employed (or employer) Proprietor.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas H. Bond.

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.

12 MAIDEN NAME OF MOTHER Mary Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.

14 Informant William J. Bond.
(Address) 618 S. Bluldin St.

MAR 18 1921

Robert P. Harrison, Registrar

Burial Permit Cleared

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 13. 1921. to March 17. 1921.

that I last saw h alive on March 17. 1921.

and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A W Reier, M. D.

3/18. 1921 (Address) Kirkside Rd. Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 21st 1921
20 UNDERTAKER Zilly & Quien	ADDRESS 400 S. Wolfe St

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 520 30

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 5-2030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 S Wolfe St.; 2 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Mohr.

(a) RESIDENCE. No. 313 S Wolfe, St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow John Mohr.

6 DATE OF BIRTH (month, day, and year) April 25

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	18,	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Schloss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Margaret Smith

(Address) 1762 Montpelier St

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 22 1921, to March 18 1921, that I last saw h[illegible] alive on March 12, 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D P Herzog M.D., M. D.

3/18, 1921 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Mar 19th 1921
20 UNDERTAKER	ADDRESS
Millard B Callender	Bank & Ann Sts

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D52031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52031

CERTIFICATE OF DEATH.

104

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 512 S. Maderia Street ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Pakuno

(Residence in Baltimore: No. 512 S. Maderia Street. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, January (Month) 5 (Day) 1921, / (Year)

7-AGE, yrs. 2 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. ------
(b) General nature of industry, business, or establishment in which employed (or employer). --------

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Pakuno

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Stefania Wontowska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Stefania Pakuno

(Address) 512 S. Maderia Street

15-

Filed MAR 19 1921, 191

Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 19 (Day) 1921, 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Syga M. D.
(Coroner.)

3/19, 1921 (Address) 1800 N. Aborden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary.	March 20, 1921.
20-UNDERTAKER	ADDRESS
M. F. Sadowski.	905 S. Ann St.

...RMANENT RECORD ...NK—T... ...GE should be stated EXACTLY. PHYSICIANS shou... ...e ...ONLY, WITH U... ...ITE P... ...ink— ...information should be careful... ...properly classified. Exact statement of OCCUPATION is very ... DEATH in plain terms, so that it ... important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D52032 HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D52038

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Evans

(Residence in Baltimore: No. 870 Tyson St

St.: yrs. 42 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	married

6-DATE OF BIRTH, ... Jan. (Month) 6 (Day), 1921 (Year)

7-AGE, 44 yrs. 2 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Porter 80
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, John H. Evans

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Margaret Green

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. M. Evans

(Address) 874 Tyson St.

15-

Filed ....., 191.....

MAR 19 1921

Robert P. Harrison, Registrar.

~~1921 Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisition (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

March 18, 1921 (Address) 2802 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

870 Tyson St.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, W. F. Auburn Road — DATE OF BURIAL, March 19 19 21

20-UNDERTAKER Samuel Hensley — ADDRESS 1778 N Bond St

Spec.—8-24-14—M. & T.—2000 Bks.

D.52033 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S Mount ST.; 19 WARD) REGISTERED NO. C 151

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Kohrner

(Residence in Baltimore: No. 317 S Mount St. St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6-DATE OF BIRTH, March (Month) 17 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. 1 ds.

If LESS than 1 day, 16 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Ed Kohrner

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Rosina Zuckerd

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed. Kohrner

(Address) 317 S. Mount St.

15-

Filed ....., 19.. Robert P. Harrison, Registrar.

MAR 19 1921 Bureau Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 17 1921, to March 18 1921, that I saw her alive on March 18 1921, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Malformation

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert F. Corkran M. D.

3/19, 1921 (Address) 2 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem	March 19, 1921
20-UNDERTAKER	ADDRESS
John F. Doran & Son	901 Hollins St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 52034

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 N. Franklin St. ST.; 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent DePaul Degnan

(a) RESIDENCE. No. 1012 N. Franklin St ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	2	4	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work: Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto - Md

PARENTS

10 NAME OF FATHER: Thomas Degnan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Kane
(Address): 1012 N. Franklin St.

15 Filed MAR 19 1921, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 15, 1921, to March 18, 1921, that I last saw h.im alive on March 17, 1921, and that death occurred, on the date stated above, at 3.05 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Health Dept for T.B.

(Signed) Robt. J. Murray, M. D.

3-19 1921 (Address) 510 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	3-21-1921
20 UNDERTAKER	ADDRESS 517 N.
H. C. Brauning & Son E. Schroeder	St

MAR 19 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

146839

D. 52035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52035

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Collins

(a) RESIDENCE. NO. 213 S Bethel st. Balto. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1yr. mos. dys. How long in U. S., If of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5 da	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Russell Collins.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sara Collins Wolcott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed MAR 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1921, to March 16, 1921, that I last saw him alive on March 16, 1921, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) W. C. Davison, M. D.

3-16, 1921 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAR 18 1921

20 UNDERTAKER: Commissioner Health,
ADDRESS

Per. Wm. E. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

no number.
D. 52036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52036
74

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Griffin.

(a) RESIDENCE. NO. 579 Greenmiller St. ST., Balto. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 6-1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 880

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Griffin.

11 BIRTHPLACE OF FATHER (city or town) Philadelphia (State or country) Pa.

12 MAIDEN NAME OF MOTHER Julia Griffin.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J. Hopkins Hosp. Records. Robert T. Harrison,

....., 19 Registrar

Burial Permit (Clerk)

MAR 19 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15- 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15. 1921, to March 15- 1921, that I last saw h[illegible] alive on March 15 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Tetany

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did on operation precede death? No. Date of

Was there on autopsy? Yes.

What test confirmed diagnosis? Electrical Reactions

(Signed) [illegible], M. D.

3/16, 1921 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL 3/18 1921

20 UNDERTAKER

ADDRESS

Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Entire statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 52037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52037

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. St Elizabeth's Home ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Green

(Residence in Baltimore: No. St. Elizabeth's Home St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	black	

6-DATE OF BIRTH, Foundling ....., 1 .....
(Month) (Day) (Year)

7-AGE, about 3 yrs. .....yrs. .....mos. .....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Foundling

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert P. Harrison, Registrar.

MAR 1 1921

Burial Permit Clerk.

Lot city burial

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 1920, to March 1921, that I saw h w alive on March 12 1921, and that death occurred, on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:

.....

Colds

(Primary, Complicating)

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Asthenia

..... (Duration) 1 yrs.....mos.....ds.

(Signed) Frank Lloyd M. D.

March 18, 1921 (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 1921

20-UNDERTAKER

ADDRESS 1921

Commissioner Health,

Per Wm. F. WOODALL

MAR 1

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52038

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52038

CERTIFICATE OF DEATH.

X 120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 Gilmor North ST.: 19 WARD)

2-FULL NAME Louise Simmons

(a) RESIDENCE. NO. 327 Gilmor North ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Simmons.

6 DATE OF BIRTH (month, day, and year) Feb 5 - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife 03

(b) General nature of Industry, business, or establishment in which employed (or employer) Cooking - Washing

(c) Name of employer Selfi

9 BIRTHPLACE (city or town) (State or country) Spartanburg S. Carolina

PARENTS

10 NAME OF FATHER Perry Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Hattie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant (Address) JOHNS

15 Filed MAR 19 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to March 17, 1921, that I last saw her alive on March 16, 1921, and that death occurred, on the date stated above, at 5.15 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis - Chronic

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Menopause.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Autopsy

(Signed) Wm. H. Wright, M. D.

1921 (Address) 1209 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL. DATE OF BURIAL 19

20 UNDERTAKER ADDRESS MAR 1 1921

Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52039

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52039

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST.: 38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa V. Murdeen

(a) RESIDENCE. No. Washington D.C. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1843 -

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	78	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) not known - Virginia -

PARENTS

10 NAME OF FATHER Thomas Murdeen

11 BIRTHPLACE OF FATHER (city or town) Norfolk (State or country) Va

12 MAIDEN NAME OF MOTHER Emma Sanford -

13 BIRTHPLACE OF MOTHER (city or town) Norfolk (State or country) Va -

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed MAR 19 1921 . 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23rd 1891, to March 19, 1921, that I last saw h[illegible] alive on March 15, 1921, and that death occurred, on the date stated above, at 12.45 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis - Complicated by Val. Dis. of Heart -

(duration) 3 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Chr. Mania -

Abt (duration) 20 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Washington D.C. -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va.	Mar 19 1921
20 UNDERTAKER Henry W. Jenkins Sons	ADDRESS McElderry Richard

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 52040

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52040

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 N. Charles ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd L. Jackson

(a) RESIDENCE. NO. 1210 N. Charles ST., 11 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state AGE carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (~~write the word~~)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie Chester Jackson

6 DATE OF BIRTH (month, day, and year) 1845-2-6

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Clarksburg West Virginia

PARENTS

10 NAME OF FATHER Joseph B. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Emily Bird Lorentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Mrs. A. E. Jackson
(Address) 1210 N. Charles St

15 Filed Mar 21 1921 Robert P. Harrison, Registrar

MAR 19 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7th, 1921, to March 19th, 1921, that I last saw him alive on March 18th, 1921, and that death occurred, on the date stated above, at 12-30 9 m.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis & Nephritis;
Chronic Bronchitis &
Marasmus
Influenza (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Coma & Marasmus

(Signed) C. B. Gamble Jr, M. D.

, 19 (Address) 26 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	8-21 1921
20 UNDERTAKER Henry A. Gutkunst & Sons Co	ADDRESS McCulloh & Orchard Sts

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 52041 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52041

CERTIFICATE OF DEATH. 60

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 N. Central Ave DIST. 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Washington

(a) RESIDENCE. No. 635 N. Central ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred all her life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 22nd 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nil.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wilbert Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Gladys Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Rosa Washington (Address) 635 N. Central ave.

15 Filed MAR 19 1921, 19 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/3/24, 19 24, to 17/3/24, 19 24, that I last saw her alive on 16/3/24, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows: Cerebral abscess, Acute Nephritis Several

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia etc

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) E. Mayfield Boyd, M. D.

(Address) 1 W. N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johns Hopkins Cemetery	Mar 20th 1924
20 UNDERTAKER Chas G Bailey	ADDRESS 1471 Fulton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52042

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52042

84

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2700 Howard Place ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmira A. Beard

(a) RESIDENCE. No. 2700 Howard Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Robert A. Beard

6 DATE OF BIRTH (month, day, and year) Sept. 30th 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Thurmont

(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Mrs. Guy E. Hartley

(Address) 2700 Howard Place

15 Filed MAR 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5. 1921, to March 17 1921, that I last saw her alive on March 16. 1921, and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis -

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. F. Robinson, M. D.

3/18. 1921 (Address) 1307 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Mch 21 1921
20 UNDERTAKER	ADDRESS
Jos Block	1003 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Naomi Lampel

D 52043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52043

9-041

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nabico Lampel

(a) RESIDENCE. No. 119 Scott ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 27 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 23 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md.

PARENTS

10 NAME OF FATHER Louis Lampel

11 BIRTHPLACE OF FATHER (city or town) Phila.
(State or country) Penn

12 MAIDEN NAME OF MOTHER Gertrude Clatsky

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D.C.

14 Informant Louis Lampel
(Address) 119 Scott St

15 Filed MAR 20 1921 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1921, to March 18, 1921, that I last saw h[illegible] alive on March 18, 1921, and that death occurred, on the date stated above, at 1:45 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) — yrs. — mos. 22 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? culture positive

(Signed) B Macpherson M. D.

3/19/21 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western cemetery	Mar 19 1921
20 UNDERTAKER	ADDRESS
N M Routson	230 N Green

Spec.—8-24-14—M. & T.—2000 Bks.

Arden C. Abrecht

D 52044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52044

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH University Hospital REGISTERED No. C.....

CITY OF BALTIMORE: (No. 614 E 27th St ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arden C Abrecht

(Residence in Baltimore: No. 614 E 27th St. St. 17 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov 7, 1903
(Month) (Day) (Year)

7-AGE, 17 yrs. 4 mos. 12 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, George F. Abrecht

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary R. Crummett

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George F. Abrecht

(Address) 614 E. 27th St.

15- Filed MAR 20 1921, 191... ROBERT A. BAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 19th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 18th 1921, to March 19th 1921, that I saw h[illegible] alive on March 19th 1921, and that death occurred, on the date stated above, at 1 [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Geo Mengert M.D.

March 19th 1921. (Address) 701 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State Life yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 614 E. 27th St.

19-PLACE OF BURIAL OR REMOVAL, Frederick Md. DATE OF BURIAL, March 22, 1921.

20-UNDERTAKER H. McCorkle ADDRESS 618 E 25th St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52045

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52045

CERTIFICATE OF DEATH.

40

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Park Heights Ave near Glen Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Kirkwood - Sr.

(a) RESIDENCE. NO. Park Heights Ave near Glen Ave ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Augusta Kirkwood.

6 DATE OF BIRTH (month, day, and year) October 31-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	4	16	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Sea Food 045

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John A. Kirkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Julia A. Hiltzheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Augusta Kirkwood. (Address) Park Heights Ave near Glen

15 FILED MAR 20 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16- 1921.

17

I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1920, to march 16, 1921, that I last saw h.im alive on March 16, 1921, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Theo. A. Morrison, M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	March 20-1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr. Friendwald - 1113 N. Charles St.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D52046

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52046

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Mc Donough ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan E. Douglass

(a) RESIDENCE. No. 1117 Mc Donough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Douglas

6 DATE OF BIRTH (month, day, and year) Mch 14, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Northumberland Co Virginia

PARENTS

10 NAME OF FATHER Daniel Headly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virg.

12 MAIDEN NAME OF MOTHER Fedelia Pyrant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virg

14 Informant (Address) James W. Douglass 1117 Mc Donough St

15 MAR 20 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1921, to Mch 18, 1921, that I last saw h alive on Mch 17, 1921, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) David Fisher, M. D.

Mch 18 1921 (Address) 1823 N. West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bur Lakewood Cem	Mch 21 1921
20 UNDERTAKER	ADDRESS
J. M. Cook	502 E Balto

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D52047

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52047

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Raborg Street ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthon Williams

(Residence in Baltimore: No. 706 Raborg Street St.; 7 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	col.	Single

6-DATE OF BIRTH. January 12, 1907
(Month) (Day) (Year)

7-AGE. 14 yrs. 2 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Shoeshiner
(b) General nature of industry, business, or establishment in which employed (or employer)..... 186

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joshua Williams

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joshua Williams

(Address) 706 Raborg St

15- MAR 20 1921 ROBERT J. KRAUTER
Filed..... 191..... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 18, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11 1921, to March 17 1921, that I saw h[illegible] alive on March 11 1921, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

..... (Duration)....yrs.....mos....7...ds.

CONTRIBUTORY (Secondary) Cd. Pneumonia

..... (Duration).....yrs.....mos....7...ds.

(Signed) C. E. Fowler M. D.

March 18, 1921 (Address) 712 S. Paca St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem'ty	3/20, 1921
20-UNDERTAKER	ADDRESS
Wm. Groff Hooe	410 E. Lanvale St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D52048

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52048

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 Vincent ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Milburn

(Residence in Baltimore: No. 1929 Vincent St.; 4 yrs., ... mos. ..... ds.)

N.B.—Every ... CAUSE OF ... important. See instructions on back of certificate. ... PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD ... tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, ... June ..... 10 ....., 1891.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
29 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 63

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, not given

11-BIRTHPLACE OF FATHER (State or Country) Not given.

12-MAIDEN NAME OF MOTHER Amanda Milburn

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nelson Worley

(Address) 929 Vincent St.

15-

Filed MAR 20 1924, 191.... ROBERT B KRAUSE

Burial Permit to Cleat

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar — 18 ....., 1924.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1924, to Mar 18 1924, that I saw h... alive on Mar 18 1924, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

a. Pneumonia

..... (Duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary) Hemiplegia & Tuberculosis

..... (Duration) ..... yrs. 2 ..... mos. ..... ds.

(Signed) Edward Short ..... M. D.

Mar 18, 1924. (Address) 1512 Druid Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	3/20, 1924
20-UNDERTAKER	ADDRESS
Jas Bart Hayes	406 W. Conway St

Spec.—6-9-19—H. P. Co.—1000 Bks.

052049

HEALTH DEPARTMENT—CITY OF BALTIMORE

052049

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 Barclay St. ST.: 12 WARD)

2-FULL NAME Katherine Akers Brice

(a) RESIDENCE. NO. 2201 Barclay St. ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 6 mos. 9 ds. How long in U. S., if of foreign birth? 55 yrs. 6 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George F. Brice

6 DATE OF BIRTH (month, day, and year) Sept-9-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	6	9	

8 OCCUPATION OF DEECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER George W. Foy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Susan Akers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Easton, Maryland

14 Informant (Address): Geo. F. Brice, (husband) 2201 Barclay Street

15 Filed MAR 20 1921 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to March 19, 1921, that I last saw h[illegible] alive on March 19, 1921, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Labor pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. S. Niblett, M. D.

March 19-21 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Mar-21-21

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

WRITE IN INK. WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052050

HEALTH DEPARTMENT—CITY OF BALTIMORE

052050

CERTIFICATE OF DEATH.

1920

REGISTERED NO.

1-PLACE OF DEATH

Roland Park

CITY OF BALTIMORE: (No. 204 Oakdale Road ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Hyland Kuhns

(a) RESIDENCE. No. 811 N. Charles Street ST., 11 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 9 mos. 8 ds. How long in U. S., if of foreign birth? 65 yrs. 9 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Vincent Kuhns

6 DATE OF BIRTH (month, day, and year) June-9-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore City Maryland

PARENTS

10 NAME OF FATHER James C. Hyland,

11 BIRTHPLACE OF FATHER (city or town) Somerset Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary P. Atkinson

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co. (State or country) Maryland

14 Informant Mr. Chas. F. Kuhns (son)
(Address) 2040 Oakdale Road, Roland Park.

15 FILED MAR 20 1921 ROBERT J. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1920, to March 18, 1921, that I last saw h[illegible] alive on March 18, 1921, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows: Uremia. (Chronic Nephritis)

(duration) - yrs. - mos. 5 ds.

CONTRIBUTORY (Secondary) Post Operative Neurosis

(duration) - yrs. 4 mos. - ds.

18 Where was disease contracted if not at place of death? At Home & Death

Did an operation precede death? Yes Date of Nov. 1920

Was there an autopsy? No

What test confirmed diagnosis? Tests for albumin, casts & blood urea.

(Signed) [illegible], M. D.

, 19 (Address) [illegible] Eutaw apt. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Mar-21-21

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEM, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE EXACTLY. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52051

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52051

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 W. Hill ST. 22 WARD)

2-FULL NAME Charles Smith

(a) RESIDENCE. No. 229 W Hill ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Macer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Ruth Macer
(Address) 229 W. Hill St

15 Filed MAR 20 1921 ROBERT F. FEUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1st 1921, to Mar 19, 1921, that I last saw h[illegible] alive on Mar 18th 1921, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastroenteritis
(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Asthenia
(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D H Lamar, M. D.

3/19/21 (Address) 140 W Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mch 21 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 142 W Hill St

N. B.—WRITE PLAINLY, WITH UNFADING INK. The Physician should state EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be st CAUSE OF DEATH in plain terms, so that it may be pro TION is very important. See instructions on back of cert

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52052

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Brakefield

(a) RESIDENCE. No. 908 Peach Alley St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Columbus Georgia

PARENTS

10 NAME OF FATHER Levi Brakefield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records
(Address) M. T. H.

15 MAR 26 1921 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 28, 1921, to March 17, 1921, that I last saw him alive on March 16, 1921, and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. J. Rigney, M. D.

3-17-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Mar 20 1921

20 UNDERTAKER R E Gross ADDRESS 1400 McElderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

252053 HEALTH DEPARTMENT—CITY OF BALTIMORE 252053

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 723 Hanover St. ST.: 22 WARD) REGISTERED NO. C. 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Witte.

(Residence in Baltimore: No. 723 Hanover St. St.: 73 yrs., 7 mos. 3 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, August 15th. 1847, 1
(Month) (Day) (Year)

7-AGE, 73 yrs. 7 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore, Md

PARENTS.

10-NAME OF FATHER, John C. Koehler.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Kunigunda.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. August Witte.)husband)

(Address) 723 Hanover St.

15- FILED MAR 20 1921 ROBERT J. KRAUTER Registrar
191... Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 18th. 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

March 19 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	March 21 191.
20-UNDERTAKER	ADDRESS
J. A. Maurer	203 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52054

154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2712 St Paul St ST.; 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine R. Sayton

(a) RESIDENCE. NO. 2112 St Paul St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or ~~divorced~~
~~HUSBAND~~ of
(or) ~~WIFE~~ of Widowed

6 DATE OF BIRTH (month, day, and year) Aug 21 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER George Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Carmor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Mr Jenkins

(Address) 2 Gay St

15 FILED MAR 20 1921 ROBERT I. KRAUTER Registrar

Daniel Parnell Oliver

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19th 1921

17

I HEREBY CERTIFY, That I attended deceased from March, 1916, to March 19th, 1921, that I last saw h. alive on March 18th, 1921, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia, general circulatory failure.

(duration) ✓ yrs. ✓ mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral softening of age (duration) 2 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) C. L. Wampler, M. D.

3.19.1921 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	March 1921
20 UNDERTAKER	ADDRESS
Henry J Jenkins Sons Co	Greenmount Ave & Eager St

N. B.—WRITE PLAINLY, WITH INK. Information supplied. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52055 — D52055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harvey T. Phillips

(a) RESIDENCE. No. Harford Ave. nr. preston st. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer 050

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Levis phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Helen McClemy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records (Address) M.T.H.

15 Filed MAR 20 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1917, to March 16, 1921.

that I last saw him alive on March 16, 1921.

and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. P. Cigrey. M. D.

3-16, 21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Patrick's Cem.

DATE OF BURIAL: 3/21 1921

20 UNDERTAKER: Chas. F. Evans & Son 118 West Royse

ADDRESS

N. B.—WRITE LEGIBLY. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D52056 HEALTH DEPARTMENT—CITY OF BALTIMORE D52056

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1621 Fleet Street ST. 7 WARD) 104

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mecyslaus Brolinski

(Residence in Baltimore: No. 1621 Fleet Street. St.; yrs., mos. ds.)

WRITE PLAINLY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Child

6-DATE OF BIRTH, October 27 (Month) (Day), 1920 (Year)

7-AGE, yrs. 4 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ------
(b) General nature of industry, business, or establishment in which employed (or employer) ------ Dd

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Wincent Brolinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Josephine Wojcila

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wincent Brolinski

(Address) 1621 Fleet Street.

15- MAR 20 1921 Filed, 191 ROBERT J KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pleuro Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. T. Ronkey M. D. (Coroner.)

3/20, 1921 (Address) 1602 Aliceanna

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	March 21, 1921

20-UNDERTAKER	ADDRESS
John H. Weber	1803 Bank St

952057

HEALTH DEPARTMENT—CITY OF BALTIMORE

952057

CERTIFICATE OF DEATH.

315-004

1-PLACE OF DEATH — Curtis Ave & Locust St. — REGISTERED No. C.

CITY OF BALTIMORE (No. Curtis Bay. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME — Stanislaus Ekstowicz.

(Residence in Baltimore: No. 333 S. Bond St. St.; yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, ... Do not know. ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
33 yrs. ---------- mos. ---------- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Farmer. .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Antoni Ekstowicz.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Frances ---------

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Teofila Just. (sister)

(Address) 333 S. Bond.

15- Filed MAR 20 1921 ROBERT J. KRAUSE Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March 16th. 1921. ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....inquiry.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ....inquiry.... find that said deceased came to ....his.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally run over and crushed by car #029 of U. Ry. & E. Co.

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Eisenhardt (Coroner) D.

March 20 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus	March 21 19 21
20-UNDERTAKER	ADDRESS
William Frackowiak	1668 Ea

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52058 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52058

CERTIFICATE OF DEATH.

61

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2043 Clifton Ave. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Francis Shields

(Residence in Baltimore: No. 2043 Clifton Ave. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March 12, 1921
(Month) (Day) (Year)

7-AGE, ...yrs.....mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....—.....
(b) General nature of industry, business, or establishment in which employed (or employer).....—.....

9-BIRTHPLACE, (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER, John Edmd. Shields

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Margaret Doherty

13-BIRTHPLACE OF MOTHER (State or Country), Boston Mass ~~Maryland~~

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E Shields

(Address) 2043 Clifford Ave.

15- Filed MAR 21 1921, 191....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to March 19 1921, that I saw h.m alive on March 18, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

1. ..... Pneumonia .....
2. .....
3. .....

(Duration)....yrs....mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration)....yrs....mos....ds.

(Signed) Helen G. Dingwall M. D.

3/19/21, 191.. (Address) 1613 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer	Mar. 21, 1921
20-UNDERTAKER	ADDRESS
E. J. Lennon & Son	[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52059

REGISTERED NO. 10-1520

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Radnor ave ST.: Gwynn 20 WARD)

2-FULL NAME Mary Francis Stubbs

(a) RESIDENCE. No. 5104 Radnor ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) DEC 29 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Simon S. Stubbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Shephard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va.

14 Informant Edw R. Hickman
(Address) 417 Cedarcroft Rd Govans

15 Filed . 19

MAR 21 1921

ROBERT J. KRAFFT
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 13, 1921, to Mch 19, 1921, that I last saw her alive on Mch 19, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

La Grippe
Infirmities of old age

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. M. Duncan, M. D.

19 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Mar 21 1921
20 UNDERTAKER	ADDRESS
Wm J Frickenstein & Sons	North Ave & Pa

INK—THIS IS A PERMANENT RECORD. Every item of above CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52060

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1945 Clifton Ave St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Euphemia Robinson

(a) RESIDENCE. No. 1945 Clifton Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred Robinson

6 DATE OF BIRTH (month, day, and year): Jan 28-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Geo. Freedenburg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mary E. Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Alfred Robinson 1945 Clifton Ave

15 Filed MAR 21 1921 [illegible] Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1921, to March 18, 1921, that I last saw her alive on March 18, 1921, and that death occurred, on the date stated above, at 4.41 m.

The CAUSE OF DEATH* was as follows:

Chr. Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Sputum etc.

(Signed) John Murray M. D.

, 19 (Address) 1271 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 3/21/21

20 UNDERTAKER: Wm J Tuckwell Son — ADDRESS: Pine & Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

D52061 HEALTH DEPARTMENT—CITY OF BALTIMORE D52061

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. East of Caroline St. St.: 3 WARD) Registered No. C 169

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Kent

(Residence in Baltimore: No. East of Caroline Street St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Unknown

6-DATE OF BIRTH, Unknown (Month) (Day) 1886 (Year)

7-AGE, 35 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Sailor
(b) General nature of industry, business, or establishment in which employed (or employer) do

9-BIRTHPLACE, (State or Country), London

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- MAR 21 1921 191.... ROBERT I. GRAVES Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 16 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D. (Coroner.)

3/30, 1921 (Address) 1200 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Schwartz Cem	3/21 1921
20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto St

W 864

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D52062 HEALTH DEPARTMENT—CITY OF BALTIMORE D52062

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2510 Oak st ST. 12-15-001 WARD) REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie E. Schmuff

(Residence in Baltimore: No. 2510 Oak st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May 22, (Month) (Day) 1848 (Year)

7-AGE, 3 yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, John F. Schmuff

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Ida.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John F. Schmuff

(Address) 2510 Oak st

15- ROBERT J. KRAUSE

MAR 21 1921 191... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck by an Automobile Accidental

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) John Grossman (Coroner) M. D.

March 29 1921 (Address) 2682 Robinson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Wood Lawn Cemtry.	March 21 1921
20-UNDERTAKER George F. Ruth	ADDRESS 735 Hanford Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT

Spec.—8-24-14—M. & T.—2000 Blks.

D52063

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52063

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1304 Greenmt ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Dyer Hunt

(Residence in Baltimore: No. 1304 Greenmount Av St.; ....yrs.,.... mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	White	Single

6-DATE OF BIRTH, 9 (Month) 11 (Day), 1920 (Year)

7-AGE, ...yrs. 6 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Sherman Hunt

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Lawrence

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sherman Hunt

(Address) 1304 Greenmount Av

15-

Filed MAR 21 1921 ROBERT F. KRAUTER

Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-15 1921, to 3-18 1921, that I saw h[illegible] alive on 3-18 1921, and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis

..... (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) D. Bernard Wilson M. D.

3/18, 1921. (Address) 914 N. Bidd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem	March 21, 1921

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Hayford ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH INK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D52064

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 W. Lanvale ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia P. Nichols

(a) RESIDENCE. No. 217 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. —— mos. —— ds. How long in U. S., if of foreign birth? —— yrs. —— mos. —— ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 4 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —— old

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) New Orleans
(State or country) Louisiana

PARENTS

10 NAME OF FATHER Dr William C. Nichols

11 BIRTHPLACE OF FATHER (city or town) New Orleans
(State or country) Louisiana

12 MAIDEN NAME OF MOTHER Virginia Polland

13 BIRTHPLACE OF MOTHER (city or town) New Orleans
(State or country) Louisiana

14 Informant Murell Nichols
(Address) 217 W. Lanvale St

15 MAR 21 1921 Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/15, 1921, to 3/18, 1921, that I last saw her alive on 3/17/21, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Secondary Anaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter A Bucky M. D.

, 19 (Address) 600 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March 21 1921

20 UNDERTAKER — ADDRESS

John P. Spence, 1325 N. Howard St

Spec.—8-24-14—M. & T.—2000 Bks.

D52065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9R D52065

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 N. Monument ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Keller

(Residence in Baltimore: No. 222 N. Monument St. 55 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): widow

6-DATE OF BIRTH, March 20, 1866
(Month) (Day) (Year)

7-AGE, 55 yrs. 0 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —at home
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joshua Yingling

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Margaret Shriver

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. E. Lemmon

(Address) 101 E. Madison St.

15- Filed MAR 21 1921, 191.... ROBERT A. ERAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3/15 1921, to March 20 1921, that I saw her alive on March 20 1921, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. E. Lemmon M. D.

3/20, 1921. (Address) 101 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, March 22, 1921

20-UNDERTAKER John R. Spencer — ADDRESS 1325 N. Carrollton

Spec.—8-24-14—M. & T.—2000 Bks.

052066

HEALTH DEPARTMENT—CITY OF BALTIMORE

052066

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2119 Walbrook Ave., 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Annie Stitt Yingling

(Residence in Baltimore: No. 2119 Walbrook Ave St., 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. May (Month) 16 (Day), 1852 (Year)

7-AGE. 69 yrs. 10 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Jacob F. Ebersole

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Stitt

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George F. Yingling

(Address) 2119 Walbrook Ave.

15- Filed MAR 21 1921, 191... ROBERT J KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH March (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-19- 1921, to 3-20- 1921, that I saw her alive on Mar. 20 1921, and that death occurred, on the date stated above, at 2:45 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ... yrs. ... mos. 2/3 ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) E. H. Holbrook M. D.

3-20, 1921 (Address) 2100 W. Northern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Winchester Va	Mar. 22, 1921
20-UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. Northern

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' terms may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52067

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Park Ave. Raspeburg ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Melvin Malkus

(a) RESIDENCE. No. 12 Park Ave. Raspeburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 16th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 600

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Malkus

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth A. Spearey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs Elizabeth A. Malkus
(Address) 12 Park ave. Raspeburg

15 Filed MAR 21 1921 19 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18th 1921

17

I HEREBY CERTIFY, That I attended deceased from March 15 1921, to March 18, 1921.

that I last saw h. alive on March 17th 1921,

and that death occurred, on the date stated above, at 1.25 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G. Webster M.D., M. D.

, 19 (Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 21 21
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Son	Fullerton Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Nortman

HEALTH DEPARTMENT—CITY OF BALTIMORE

52068 52068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital 6 146

CITY OF BALTIMORE: (No. ..... ST.: ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Nortman

(a) RESIDENCE. NO. 3101 E. Fayette ST., WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Charles Nortman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Anna Schmaus

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Charles Nortman
(Address) 3101 E Fayette St

15 Filed MAR 21 1921 19 ... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1921, to Mar 20, 1921, that I last saw h[illegible] alive on Mar 20, ..., 19 21, and that death occurred, on the date stated above, at 7.40 p.m.

The CAUSE OF DEATH* was as follows:

Abscess of brain

(durstion) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(durstion) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically —

(Signed) F. C. Manns, M. D.

3-20, 1921 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Mar 23

20 UNDERTAKER Sauls Heemeyer

ADDRESS 32 S Broadway

Spec.—6-9-19—H. P. Co.—1000 lbks.

D52069

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52069

CERTIFICATE OF DEATH.

29

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 E. Madison ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russel Butler

(a) RESIDENCE. No. 1006 E Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Mulatto	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Bedford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret Bedford
(Address) 1006 E Madison

15 MAR 21 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 18 1921

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 18, 1921, that I last saw him alive on March 16, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Arthur Deaver, M. D.

3/17. 1921 (Address) 1600 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 22 1921

20 UNDERTAKER Milton Davis ADDRESS 713 N Eden St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 E. Preston St.: 9 WARD)

REGISTERED NO. 80

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Morgan Logan

(a) RESIDENCE. NO. 1204 E. Preston ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know

6 DATE OF BIRTH (month, day, and year): July 18, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Lancaster Co., Pennsylvania

PARENTS

10 NAME OF FATHER: Hugh Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Ellen Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Nellie Deegan

(Address): 1204 E. Preston Street

15 Filed MAR 21 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/18 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 1919, to 3/18, 1921, that I last saw h[illegible] alive on 3/18, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary): Nothing

(duration) -- yrs. -- mos. -- ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ....Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) C H Hayward, M. D.

3/19, 1921 (Address) 23 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patrick's Cemetery	3/20 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Marie Carroll. D52071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52071

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary E. Carroll

(a) RESIDENCE. No. 5 N. Exeter St., Ward. North Randall Ohio

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Samuel Carroll

6 DATE OF BIRTH (month, day, and year) Dec. 5, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Louis Detwiler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Eliza Bodmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Marie Carroll (Address)

15 Filed MAR 21 1921 ROBERT J. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3, 18 1921

17 I HEREBY CERTIFY, That I attended deceased from 3, 2 , 1921, to 3, 18 , 1921, that I last saw h[er] alive on 3, 18 , 1921, and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Typ - Hydrothorax

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3, 21, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
North Randall Ohio	March 21 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

952072

HEALTH DEPARTMENT—CITY OF BALTIMORE

952072

CERTIFICATE OF DEATH.

REGISTERED NO. 1014

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1450 Hiemier ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Charles Richel

(a) RESIDENCE. No. 1450 Hiemier St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER George Richel

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Kramer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs Theresa Richel
(Address) 1450 Hiemier St

15 Filed MAR 21 1921 ROBERT A. GAUTIER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/12, 19 21, to 3/19, 19 21,
that I last saw h[illegible] alive on 3/19, 19 21,
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Marasmus
(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Dixon M. D.

, 19 (Address) 1337 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	March 21 1921
20 UNDERTAKER	ADDRESS
Wm Cowles	Ag St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

DeHaven.

D52073

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52073

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 N. Wolfe ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Chas J. de Haven

(a) RESIDENCE. No. 1613 N. Wolfe ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Chas J. de Haven

6 DATE OF BIRTH (month, day, and year) Jan - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt.	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mifflin Township Ohio

PARENTS

10 NAME OF FATHER John Gatchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mifflin Township Ohio

12 MAIDEN NAME OF MOTHER J. Gatchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mifflin Township Ohio

14 Informant Charles J. de Haven

(Address) 1612 N. Wolfe St.

15 MAR 21 1921

ROBERT I. KRAUTER Registrar

Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1921, to Mar 20, 1921, that I last saw h.. alive on Mar 19, 1921, and that death occurred, on the date stated above, at 10.05 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical Chemical

(Signed) J. N. Edwards, M. D.

Mar 20, 1921 (Address) 1228 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL March 23 1921

20 UNDERTAKER William Cook

ADDRESS 502 E. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52074

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-1 D52074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andreas Lucas

(a) RESIDENCE. No. 1740 N. Bond St. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant New City Hosp Records
(Address)

15 FILED MAR 21 1921 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-18, 1921, to 3-20, 1921, that I last saw h/M alive on 3-19, 1921, and that death occurred, an the date stated abave, at 1.50 a. m.

The CAUSE OF DEATH* was as fallaws:

Cystitis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (duration) ..... yrs. mos. 6 ds.

18 Where was disease eantracted if not at place of death? —

Did an operation preeede death? No Date of .....

Was there an autopsy? Yes. .....

What test confirmed diagnasis? autopsy

(Signed) F. A. Holden, M. D.

3-20, 1921 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature af Injury, and (2) whether Aecidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 3/22 1921.

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

See 1x Columbia Ave near Fulton.

D52075

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52075

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH Columbia

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1143 Col Ave ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie F. Rost (Rost.)

(a) RESIDENCE. No. 1143 Col Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas C. Rost

6 DATE OF BIRTH (month, day, and year) July 18 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Said to Have

11 BIRTHPLACE OF FATHER (city or town) (State or country) Said to Have

12 MAIDEN NAME OF MOTHER Said to Have

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Said to Have

14 Informant Mrs Louise Pleiss (Address) 1143 Col Ave

15 Filed MAR 21 1921 ROBERT F. CRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 18, 1921, that I last saw her alive on, March 18, 1921, and that death occurred, on the date stated above, at 4-30 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) L. M. Lumpkin, M. D.

(Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Mch. 21 1921
20 UNDERTAKER H. M. Cook	ADDRESS N. Gilmor

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D52076

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52076

CERTIFICATE OF DEATH.

Mad 932.119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 East Eager ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Patterson

(a) RESIDENCE. NO. 1719 East Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: daughter of Pate

Joseph + Kate Patterson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER: Joseph Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Kate Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Kate Patterson

(Address) 1719 E. Eager

MAR 21 1927

15 Filed 19 Burial Permit Issued

622 N. Bond St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 18 1927

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1927, to March 18, 1927,

that I last saw h[illegible] alive on March 16, 1927,

and that death occurred, on the date stated above, at 1055 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Gibney, M. D.

3/14, 1927 (Address) 622 N. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 3/21 1927

20 UNDERTAKER: William Cook

ADDRESS: Son & North

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. PHYSICIANS should be stated EXACTLY. PHYSICIAN'S address should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52077

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901 Arlington ST.: 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Fichtner

(Residence in Baltimore: No. 2901 Arlington Av. St.; 70 yrs. mos. ds.)

N.B.—Every item of information should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Nov. (Month) 1 (Day), 1836 (Year)

7-AGE, 84 yrs. 4 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dorst Linn

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dorst Linn

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis A. Voll

(Address) 2901 Arlington Ave Baltimore

15-

Filed MAR 21 1921 ROBERT B KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 6 1921, to March 19 1921, that I saw h[illegible] alive on March 18 1921, and that death occurred, on the date stated above, at 12.15 a m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) 1 yrs. mos. ds.

(Signed) Louis A. Voll M. D.

March 19, 1921. (Address) 1005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Holy Redeemer — DATE OF BURIAL, March 23 1921.

20-UNDERTAKER Jos J. Herr — ADDRESS 106 N. Luzerne

D52078

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D52078

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2811 Harlem Ave ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ernst P. Schellert

(Residence in Baltimore: No. 2811 Harlem Ave St.: 46 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PERMIT

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH April 7th, 1874
(Month) (Day) (Year)

7 AGE 46 yrs. 11 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9 BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Ernst Schellert

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Uhl

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Katie Schellert

(Address) 2811 Harlem Ave

15. Filed MAR 21 1921 ROBERT J KRAUTER Registrar of Vital Statistics
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 18, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1921 to Mar. 18, 1921, that I saw him alive on Mar. 18, 1921, and that death occurred, on the date stated above, at 3.50 P. m.
The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 1 yrs. 1 mos. 4 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Vernon H. Condon M. D.

....., 191.... (Address) 750 N. Northern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery

DATE OF BURIAL: Mar 24 1921

20 UNDERTAKER: F. B. Heppert

ADDRESS: 2336 Frederick Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2452079 (14660) 2452079

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Fasmendo

(a) RESIDENCE. No. 1322 Pennsylvania Ave Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18-1886

7 AGE: 35 Years | 2 Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10 NAME OF FATHER: Joseph Machal

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Eliza McDonnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Hospital Record
(Address) Johns Hopkins Hospital

15 Filed MAR 21 1921 ROBERT A. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 18-1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1921, to March 18, 1921, that I last saw h[illegible] alive on March 18, 1921, and that death occurred, on the date stated above, at 11:45 p. m.

The CAUSE OF DEATH* was as follows:

Septic Lobar Pneumonia
following pregnancy.

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Hemolytic staphylococcus septicaemia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological, cytological & Surgical

(Signed) Edward C. Davidson M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Mar 22 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Harwood Hill Ave

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 145-811 D 52080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 52080

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp St. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexia Connor

(a) RESIDENCE. No. 1201 Broad Hall Ave ST. ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. unknown mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48		1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Alexis Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Julia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant ..... (Address) Hospital Record

15 Filed MAR 21 1921 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1921, to March 18, 1921, that I last saw h alive on March 18, 1921, and that death occurred, on the date stated above, at 3 35 P m.

The CAUSE OF DEATH* was as follows: Cirrhosis of liver

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal Hepatic Coma (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes Pathological findings

What test confirmed diagnosis? Histology

(Signed) Edward C. Davidson M. D.

3/19, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mch 24 1921
20 UNDERTAKER Sam'l H. Glass & Son	ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in the statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should be careful in the statement of OCCUPATION should be carefully supplied. AGE

Spec.—8-24-14—M. & T.—2000 Bks.

Smithwick

D52081 HEALTH DEPARTMENT—CITY OF BALTIMORE D52081

CERTIFICATE OF DEATH.

REGISTERED No. C 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Druid Hill Av St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Evelyn Smithwick

(Residence in Baltimore: No. 1629 Druid Hill Av St.; ..... yrs., 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Fem	Col	Single

6-DATE OF BIRTH, Feb 18, 1921 (Month) (Day) (Year)

7-AGE, ... yrs. 1 mos. 2 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Herbert Smithwick

11-BIRTHPLACE OF FATHER (State or Country), Sydney N.C.

12-MAIDEN NAME OF MOTHER Jena Bannister

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jena Smithwick

(Address) 1629 Druid Hill Ave

15- ROBERT J. KRAUSE

FILED MAR 21 1921 191.. Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 18 1921 to March 19 1921, that I saw her alive on March 19 1921, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Failure of Closure of Foramen Ovale

(Duration) ... yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) General Oedema

(Duration) ... yrs. ... mos. 14 ds.

(Signed) S B Hughes M. D.

March 20, 1921. (Address) 1413 D Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	March 21, 1921
20-UNDERTAKER	ADDRESS
Saml H. Evans Sr	1400 Maher

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D52082

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52082

CERTIFICATE OF DEATH.

10-078

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2933 Greenmount Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Eleanor Virginia Scarbrough

(Residence in Baltimore: No. 2933 Greenmount Ave St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 23, 1860
(Month) (Day) (Year)

7-AGE, 60 yrs. 5 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Isaac Godman Roberts

11-BIRTHPLACE OF FATHER (State or Country), Kent Co. Md.

12-MAIDEN NAME OF MOTHER, Eleanor Ensenger

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Scarbrough

(Address) 2933 Greenmount Ave

15- Filed MAR 21 1921 [illegible] Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 26 1921, to Mar 18 1921, that I saw h[illegible] alive on Mar 14 1921, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Rosanne Fetter M. D.

Mar 18, 1921 (Address) 2935 Greenmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Mch 21, 1921

20-UNDERTAKER E Le Roy Stiffler

ADDRESS 125 E North Ave

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. F. Co.—1000 Bks.

D52083 HEALTH DEPARTMENT—CITY OF BALTIMORE D52083

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 200 S. 3rd ST.; 76 WARD) 92-010 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Frederick

(a) RESIDENCE. No. 200 S. 3rd ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Frederick

6 DATE OF BIRTH (month, day, and year) Jan 2 - 82

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Butter Business

(c) Name of employer J. Bachman & Sons

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jennie Frederick
(Address) 200 S. 3rd St.

15 MAR 21 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 14, 1921, to Mar. 17 1921, that I last saw him alive on Mar. 17, 1921, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Path. & Obs.

(Signed) G. G. Rush, M. D.

Mar 18 1921 (Address) Charles & Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	3/21 1921
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D52084

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52084

CERTIFICATE OF DEATH.

175-D52084

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Edward Pistel

(Residence in Baltimore: No. 765 St Peter St.

St.: yrs., 56 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, Aug (Month) 25 (Day), 1864 (Year)

7-AGE 56 yrs. 7 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Driver
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John Pistel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Jacobs

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Leo Schaeffer

(Address) 1800 E. Monument St.

15-

FILED MAR 21 1921 [illegible]

Burial Permit [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic fall off

Horse,

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] Smith, M. D.

3-20, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	March 21, 1921
20-UNDERTAKER	ADDRESS
William G. Schaeffer	1816 Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 52085

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52085

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Oak ST.; 12 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Duffy

(Residence in Baltimore: No. 327 E 20 St.; ..... yrs., ... mos. ..... ds.)

4 hrs 7 hrs

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, March 20, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 4 hrs. or 40 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Owen T. Duffy

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catherine Deschler

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Owen Duffy

(Address) 327 E 20 St

15-

Filed MAR 21 1921 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 20 1921, to March 20 1921, that I saw her alive on March 20 1921, and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Premature

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Kolsch, M. D.

March 20, 1921 (Address) 728 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, March 22, 1921

20-UNDERTAKER H. M. Faulkner

ADDRESS 1124 McKeyes

N. B.—Every item of information should be carefully applied for. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D52086 HEALTH DEPARTMENT—CITY OF BALTIMORE D52086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3923 Belvieu Ave ST.: 15 WARD) 64

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Roulstan

(Residence in Baltimore: No. 3923 Belvieu Av St.; 46 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	Single

6-DATE OF BIRTH, December 23, 1874
(Month) (Day) (Year)

7-AGE, 46 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robt. Roulston

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Margaret McLean

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Roulston

(Address) Belvieu Ave, N. Arlington.

15-FILED MAR 21 1921 ROBERT J. FEAR Registrar.

Filed....., 191.... Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jas (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
5 minutes (Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) no history

(Duration).....yrs.....mos.....ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

March 21, 1921. (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore County	Mar. 21, 1921
20-UNDERTAKER	ADDRESS
David McLean	1018 Edmondson Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52087

102

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3726 Kossuth ST.: 20 WARD)

2-FULL NAME Chas. N. C. Johnson

(a) RESIDENCE. NO. 3726 Kossuth ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~her, WIFE of~~ Mary J. Johnson

6 DATE OF BIRTH (month, day, and year) July 17 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter Carrier do

(b) General nature of industry, business, or establishment in which employed (or employer) Balto P.O. do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel P. Johnson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mary J. Johnson (Address) 3726 Kossuth St

15 MAR 21 1921 ROBERT J. KRAMER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to March 17, 1921, that I last saw h— alive on March 17, 1921, and that death occurred, on the date stated above, at 10. P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. — mos. ds.

CONTRIBUTORY (Secondary) Senile Ulcer

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Howard W Jones M. D.

March 19, 1921 (Address) 222 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK.	MAR 21 1921
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52088 Wiley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52088

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Druid Hill Ave ST. 17 WARD)

2-FULL NAME Benjamin Wiley

(a) RESIDENCE. No. 1110 Druid Hill Ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah J Wiley

6 DATE OF BIRTH (month, day, and year): Unknown 1873

7 AGE: Years 48; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Meat Packer
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Eastern Shore Md

PARENTS

10 NAME OF FATHER: Chas Wiley Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Sarah Wiley
(Address) 1110 Druid Hill Ave

15 MAR 21 1921 ROBERT J KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1921

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1921, to March 19, 1921, that I last saw him alive on March 19, 1921, and that death occurred, on the date stated above, at 10.0 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? 1110 Druid Hill Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation Clinical Symptoms

(Signed) A W Flowers, M. D.

, 19 (Address) 772 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: Mar 22 1921

20 UNDERTAKER: Samuel V Hemsley — ADDRESS: W Balto

N. B.—Write plainly with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D52089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Myrtle Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ethel Taylor

(a) RESIDENCE. No. 1435 Myrtle Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Taylor

6 DATE OF BIRTH (month, day, and year): October 1880

7 AGE — Years: 31 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: James Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sallie Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Robert Taylor (Address) 1435 Myrtle Ave.

15 MAR 21 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to March 19, 1921, that I last saw h[illegible] alive on March 14, 1921, and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cachexia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Nov 3/20

Was there an autopsy? No

What test confirmed diagnosis? Microscopic section

(Signed) Charles J Brook. M. D.

March 21st (Address) 5030 Ford St. City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Orday Station Va — DATE OF BURIAL: Mar 24 21

20 UNDERTAKER: Samuel J Hemsley — ADDRESS: McDaniel

mation should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52090

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
Mt Hope Retreat
CITY OF BALTIMORE: (No. Baltimore ST.: 28 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Bodmann (BODMANN)

(a) RESIDENCE. NO. Baltimore (3219 Hillman ST.?) WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Born Germany — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Abt	87	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) Germany

12 MAIDEN NAME OF MOTHER A. A. Curtis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Denmark

11 Informant Records of Mt Hope Retreat
(Address) Mt Hope Retreat Md.

15 MAR 21 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31st 1919, to March 20th 1921, that I last saw h.r alive on March 19 1921, and that death occurred, on the date stated above, at 3.45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage. Complicated by Convulsions (Eclampsia)

Abt (duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Terminal Dementia - Post Senile Mania Abt (duration) 4 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

March 20, 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	3/22 1920
20 UNDERTAKER	ADDRESS
H. W. Maas & Son	805 N. Calvert St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

D 52091

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 52091

1 PLACE OF DEATH

Registered No. C .....

City of Baltimore (No. 322 E Biddle 10 St.: Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary McQuillan

(Residence in Baltimore: No. 322 E Biddle St.: 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Mar 18, 1848 (Month) (Day) (Year)

7 AGE: 73 yrs. 3 mos. ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick O'Brien

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Maloy

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Catherine McQuillan

(Address) 322 E Biddle St

15 Filed MAR 21 1921 191 ROBERT F. [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar 19, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1921, to Mar 19 1921, that I saw her alive on March 19, 1921 and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Frenton M. D.

March 20, 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: Mar 22, 1921

20 UNDERTAKER: Mc Ginnis & Carroll.

ADDRESS: 4203 Ridgewood Ave

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D52092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52092

CERTIFICATE OF DEATH.

REGISTERED NO. 1920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1343 N Calhoun ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Desfueldis

(a) RESIDENCE. NO. 1343 N Calhoun ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Desfueldis

6 DATE OF BIRTH (month, day, and year) unknow

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER unknow

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknow

12 MAIDEN NAME OF MOTHER unknow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknow

14 Informant Sarah Desfueldis

(Address) 1343 N. Calhoun St.

15 MAR 21 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to Mar 18, 1921, that I last saw h alive on Mar 18, 1921, and that death occurred, on the date stated above, at 4 am m.

The CAUSE OF DEATH* was as follows:

Cer Dis Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas H Whitten M. D.

3/18. 1921 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar. 21 1921
20 UNDERTAKER	ADDRESS
James P Dennis	303 Park Ave

mation should be carefully supplied. Age should be stated EXACTLY. Fictitious names must not be used.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

052093 HEALTH DEPARTMENT—CITY OF BALTIMORE 052093

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1612 Presbury ST.: 15 WARD)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Brown

(Residence in Baltimore: No. 1612 Presbury Sr. St.: 37 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, November, 15, 1884
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
37 yrs. mos. ds.	....hrs. or....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gang Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): 039

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm. L. Brown

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Dorsey

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Benj. Brown

(Address) 1612 Presbury St.

MAR 21 1921

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

10 minutes. (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Ms History

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. T. Hennessy M. D.
(Coroner.)

March 20 1921 (Address) 2803 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Mar. 21, 1921

20-UNDERTAKER	ADDRESS,
James H Dennis	1305 Brentwood St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D52094 HEALTH DEPARTMENT—CITY OF BALTIMORE D52094

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1630 Thames Street. St.: 2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Gorski

(Residence in Baltimore: No. 1630 Thames Street St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March 19 1921, 1
(Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(h) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Wladislaus Gorski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Bronislawa Kuckborska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wladislaus Gorski

(Address) 1630 Thames St

15- MAR 21 1921, 191.. Burial ... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21/ 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
.....find that said deceased came to.....death on the day stated above.
The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
Coroner.

3/21, 191.. (Address) 1602 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, Mar 22, 1921

20-UNDERTAKER W. F. Sadowski ADDRESS 705 S. Ann St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52095

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6-04 D52095

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 918 S Paca ST.; 21 WARD)

2-FULL NAME John F. Lehmayer

(a) RESIDENCE. NO. 918 S Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER John E. Lehmayer

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Blanche L. Chamberlain

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant John E. Lehmayer
(Address) 918 S. Paca St

15 Filed MAR 21 1921 ROBERT I. GRAFTON Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to March 20, 1921, that I last saw h alive on March 20, 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell, M. D.

19 1921 (Address) 647 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Mar. 21 1921
20 UNDERTAKER Margaret G. F. Flynn	ADDRESS 1432 Light St.

mation should be carefully supplied. Age should be stated EXACTLY. If information is not known, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-52096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-52096

1-PLACE OF DEATH Mercy Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. Calvert St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Sparks

(a) RESIDENCE. No. 426 Park St ST., WARD.

(Usunl place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Burrell Sparks

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary E Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant James B Sparks

(Address) 426 Park St

15 Filed MAR 21 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from February 2, 1921, to March 21, 1921, that I last saw him alive on March 21, 1921, and that death occurred, on the date stated above, at 1.25 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Epithelial Carcinoma of Uterus

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Mar 11, 21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Martindale, M. D.

19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Conway South Carolina	March 22 1921
20 UNDERTAKER	ADDRESS
Jos Jenkins & Son	207 E Pacu

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52097

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St.) (WARD)

2-FULL NAME Alvin Livingston.

(a) RESIDENCE. NO. 1818 Ashland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore.
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles E. Livingston

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Cely Burns 3/21/21

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Cecil Livingston
(Address) 1818 Ashland Ave

15 MAR 21 1921 ROBERT J. KLAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to March 21, 1921, that I last saw him alive on March 20, 1921, and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal.

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) malnutrition.

(duration) 1 yrs. 6 mos. 18 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Ellagowan M. D.

(Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Mar 2/1921
20 UNDERTAKER Clark J. Turner	ADDRESS 1424 Pine

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52098

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52098

29

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sebastian Pellot

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Porto Rico

PARENTS

10 NAME OF FATHER Asinforiano Pellot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Porto Rico

12 MAIDEN NAME OF MOTHER Rosenda Ciruz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Porto Rico

14 Informant Hospital Records,
(Address) New City Hospital.

15 MAR 21 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from October 21, 1919, to March 18, 1921, that I last saw him alive on March 18, 1921, and that death occurred, on the date stated above, at 8:35 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Joints - (all)

(duration) yrs. 16 mos. ds.

CONTRIBUTORY (Secondary) Septicemia and acute Miliary TB. (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) F. A. Holden, M. D.

3/19/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL [illegible] REMOVAL: Sacred Heart Cemetery

DATE OF BURIAL 3/21 1921

20 UNDERTAKER Mrs N. S. Fink

ADDRESS 1835 W Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052099

HEALTH DEPARTMENT—CITY OF BALTIMORE

052099

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Richter,

(a) RESIDENCE. NO. Preston & Valley Sts. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Husband of Louisa Busch

6 DATE OF BIRTH (month, day, and year) Nov 18 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Henry Richter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Germ

12 MAIDEN NAME OF MOTHER Catherine Busch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sister Florence Supr.
(Address) Preston & Valley Sts

15 Filed MAR 21 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1921

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 .. to ..... 19 ..,

that I last saw him alive on March 13, 1921,

and that death occurred, on the date stated above, at 12.15 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. A. Osborn, M. D.

21, 1921 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Mar 21 1921

20 UNDERTAKER ADDRESS

H. C. Wiedefeld 914 Greenmount

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52100

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 E Randall ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Severn

(a) RESIDENCE. No. 115 E Randall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 078

(b) General nature of industry, business, or establishment in which employed (or employer) R. R.

(c) Name of employer B & O

9 BIRTHPLACE (city or town) (State or country) Sykesville Md

PARENTS

10 NAME OF FATHER John Severn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Dean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Albert Severn

(Address) 115 E Randall

15 MAR 21 1921 ROBERT J. BRAUNE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to Mar 20, 1921, that I last saw him alive on Mar 20, 1921, and that death occurred, on the date stated above, at 10 45 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urine

(Signed) Wm E Stigler, M. D.

3/21 1921 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodbine Carroll Co. Md.	3/23 1921

20 UNDERTAKER	ADDRESS
I. Few McCully	130 E. Fort

mation should be carefully supplied. AGE should be stated EXACTLY. If uncertain, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52101

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1539 Covington ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora May Smith

(a) RESIDENCE. NO. 1539 Covington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norman Smith

6 DATE OF BIRTH (month, day, and year) June 16 '891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John F. Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Rachel Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) James Smith 1539 Covington St

15 Filed MAR 21 1921 19 ROBERT J. CRAWFORD Registrar Burial Permit Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 24, 1921, to Mar 20, 1921, that I last saw her alive on Mar 20, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

about 1½ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys & Lab

(Signed) Wm E Stifler, M. D.

3/24. 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	3/23 1921
20 UNDERTAKER	ADDRESS
I. Frew McCully	130 E. Fort

mation should be carefully supplied. AGE should be stated EXACTLY. If child is under one year, state AGE in hours or days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

052102 HEALTH DEPARTMENT—CITY OF BALTIMORE 052102

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 184

CITY OF BALTIMORE (No. Franklin Square Hospital ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myrtle Higgs

(Residence in Baltimore: No. 500 W 27th St

St. (yrs., 15 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
33 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home 037

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Andrew Pettie

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John O Higgs

(Address) 500 W 27th St

15- MAR 21 1921 ROBERT I LAUER
Filed ....., 191.... Registrar.
Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March 20 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Investigation .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... Investigation .....
(Inquest, autopsy or inquiry.) find that said deceased came to ..... her ..... death on the day stated above.
The CAUSE OF DEATH* was as follows:
Abortion Probably Self Induced, one wk's duration

..... (Duration) ..... yrs. ..... mos. 3 ..... ds.
CONTRIBUTORY (Secondary) Pulmonary Embolism Sudden
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) James W Fenton ..... M. D.
(Coroner.)
March 21, 1921. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. 5 ds. In the State 15 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
500 E 27th St
Former or usual residence 500 E 27th St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Marys Hampden	March 22 21

20-UNDERTAKER ..... ADDRESS
Brenowitz Son Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

052103

HEALTH DEPARTMENT—CITY OF BALTIMORE

052103

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Ryan west-Rogue ST. (Heights) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Everett Wallis.

(a) RESIDENCE. No. 4 Ryan west-Rogue ST. Heights WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Wallace

6 DATE OF BIRTH (month, day, and year) Jan 2-1853

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper Cashier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Nisbury & Co 608 Balto Md.

9 BIRTHPLACE (city or town) (State or country) Baltd Md.

PARENTS

10 NAME OF FATHER Edward Wallis

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Mrs Mary A Wallis

(Address) 4 Ryan West Rogue Heights

15 MAR 21 1921 BOARD OF HEALTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1- 1921, to March 20 1921, that I last saw h.im alive on March 20 1921, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Dilitation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ...Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Martin W Shuh, M. D.

3 20 1921 (Address) 1041 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 22
20 UNDERTAKER Bertram W Gore	ADDRESS 723 N Eutaw St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

952104 HEALTH DEPARTMENT—CITY OF BALTIMORE 952104

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 40 White ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Jane Williams

(a) RESIDENCE. NO. 40 White ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jany 16-1849

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
72	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none.

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Portsmouth Va

PARENTS

10 NAME OF FATHER John J. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Old Point Va.

12 MAIDEN NAME OF MOTHER Ann E. Jennings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va

14 Informant Mrs Ja Williams
(Address) 40 White ave Hamilton Md

15 MAR 21 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 13 , 1921 , to March 20 , 1921 ,
that I last saw her alive on March 20 , 1921 ,
and that death occurred, on the date stated above, at 1150 P. m.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Morris B. Green , M. D.

3/21. 1921 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Portsmouth Norfolk Va	Mch 22 1921
20 UNDERTAKER	ADDRESS
Bertram & Joyce	1723 N Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 52105 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D 52105

CERTIFICATE OF DEATH.

REGISTERED NO. C 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1433 McElderry St ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Elizabeth Hall

(Residence in Baltimore: No. 1433 McElderry St St.; 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Widow

6-DATE OF BIRTH, unknown ....., 1840.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
80 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Noal

(Address) 1433 McElderry

15-

Filed ..... Robert F. Harrison, Registrar.

MAR 21 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 20 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 3-14-21 191..., to 3-19-21 191..., that I saw h[illegible] alive on ..." 191..., and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

acute Rheumatism

..... (Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Senility, Senile Debility

Dyspepsia (Duration) ... yrs. 8 mos. ... ds.

(Signed) F. H. Carozo M. D.

3-21-21 191... (Address) 1524 N. Hilldale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	March 22, 1921
20-UNDERTAKER	ADDRESS
H. C. Frost	1405 McElderry St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52106

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52106

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH Baltimore Md

REGISTERED NO.

CITY OF BALTIMORE: (No. 614 W Mulberry ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonio Salvatore Russo

(a) RESIDENCE. No. 614 W. Mulberry St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ~~4~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25th 1919

7 AGE — Years: 1 — Months: 6 — Days: — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) 614 W. Mulberry St Baltimore, Md.

PARENTS

10 NAME OF FATHER Peter Russo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Annie Zoboig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant Peter Russo
(Address) 714 Mulberry St

15 Filed Robert P. Harrison, Registrar

MAR 21, 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to Mar 20th, 1921, that I last saw him alive on Mar 20th, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

complicated with Pleurisy

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? 614 W. Mulberry St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William Dew, M. D.

, 19 (Address) 1742 Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Mar 22 1921

20 UNDERTAKER: W. H. L. Rountree — ADDRESS: 230 N Green St

mation should be carefully supplied. AGE should be entered in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52107

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST.: 16 WARD)

2-FULL NAME Mrs. Martha M. Frith

(a) RESIDENCE. No 1137 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius R Frith

6 DATE OF BIRTH (month, day, and year) Oct 3, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm. J. Faldt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Faldt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Julius R. Frith
(Address) 1137 N. Mount St.

15 Filed ..... 19 ..... Registrar Robert P. Harrison,

APR 2 1921 Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 16, 1921, to Mar 20, 1921, that I last saw h e alive on Mar 20, 1921 and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, with acute exacerbation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation for Cholecystatis & cholelithiasis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Mar 18, 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lyman S. Abbott, M. D

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Mar 22 1921
20 UNDERTAKER	ADDRESS
Mc Mus John W. Teufel & Son	201 W. Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

4667

D. 52108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52108

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Boyce

(a) RESIDENCE. No. 1419 E. Madison St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1. 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Donald Boyce.

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies.

12 MAIDEN NAME OF MOTHER Wilhelmina Griffith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies.

14 Informant Johns Hopkins Hospital Records
(Address) Robert L. Harrison.

13 Filed MAR 21 1921, 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1921, to March 20, 1921, that I last saw her alive on March 20, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X ray

(Signed) M Davidson, M. D.

, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 22 1921
20 UNDERTAKER John W Henderson	ADDRESS 1503 E Monument

mation should be carefully supplied. Age and
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Jennie Bryan

D. 52109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52109

10-066

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 E. Madison St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Bryan

(a) RESIDENCE: No. 1626 E. Madison St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Bryan

6 DATE OF BIRTH (month, day, and year) [illegible] 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Todd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John W. Henderson, (Address) 1502 E. Monument St

15 MAR 21 1921

16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19- 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-13- 1921, to 3-19- 1921, that I last saw h[illegible] alive on March 18- 1921, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas C Carey, M. D.

, 19 (Address) 1063 Myrtle ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	March 23 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

Information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D.52110 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 127 Richmond ST.; 11 WARD) 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Manley Hutchins

(Residence in Baltimore: No. 127 Richmond St. St.; ..... yrs., 2 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Jan. (Month) 6 (Day), 1921 (Year)

7-AGE, ... — yrs. 2 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Stanley J. Hutchins

11-BIRTHPLACE OF FATHER (State or Country). Monkton Md

12-MAIDEN NAME OF MOTHER Gladys Manley

13-BIRTHPLACE OF MOTHER (State or Country). Boston

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gladys Manley

(Address) 127 Richmond St

15-

Filed ..... Robert P. Harrison, Registrar.

MAR 31 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 21st (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2d 1st 1921, to 3rd 21st 1921, that I saw h-r alive on ~~3d~~ 3rd 18 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

..... Marasmus

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. E. MacCrae M. D.

3/21st, 1921 (Address) 2017 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Westview Cemetery — DATE OF BURIAL: March 22, 1921

20-UNDERTAKER: Josiah Lyle — ADDRESS: 1600 W North Ave

(1) Every item of information must be given, if obtainable, and the certificate must be filled out in ink or typewriting. (2) The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.52111 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.52111

CERTIFICATE OF DEATH. 81

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2526 E Hayette St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Leonard

(a) RESIDENCE. No. 2526 E Hayette ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19-1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic servant

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Walter Hopkins

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Charles Leonard.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Maria Kraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John W Leonard (Address) 2526 E Hayette St.

15 Robert P. Harrison, Registrar

MAR 21 1921

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1918, to Mch 19, 1921, that I last saw her alive on Mch 20, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Ruptured Thoracic Aneurism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Thoracic Aneurism

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Geo McLean, M. D.

3/20, 1921 (Address) 20 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	March 23 1921
20 UNDERTAKER	ADDRESS
ME Gosson.	870 W 37 St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52112

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rear 1103 Laurens ST.: 16 WARD)

2-FULL NAME Julius Johnson

(a) RESIDENCE. No. Rear 1103 Laurens ST., WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Franklin
(Address) Rear 1103 Laurens

15 MAR 22 1921 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 1920. to March 20 1921.

that I last saw h— alive on March 20 1921.

and that death occurred, on the date stated above, at 12-30 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Asthma (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Wm Kostin, M. D.

3-21 1921 (Address) 2008 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mch 22 1921
20 UNDERTAKER	ADDRESS
Sam'l W. Crane Son	1408 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. Information may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 52113

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D. 52113

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2518 Salem St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and nomber and fill out No. 18.)

2-FULL NAME James George Durner

(Residence in Baltimore: No. 2518 Salem St.; X yrs. 5 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
M	W	Single

6-DATE OF BIRTH: Oct (Month) 12 (Day), 1921 (Year)

7-AGE: ..... yrs. 5 mos. 9 ds. If LESS than 1 day, ... hrs., or .... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE (State or country) Mary Land

PARENTS

10-NAME OF FATHER Joseph Walter Durner

11-BIRTHPLACE OF FATHER (State or country) Mary Land

12-MAIDEN NAME OF MOTHER Minnie Castle

13-BIRTHPLACE OF MOTHER (State or country) Mary Land

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph W. Durner

(Address) 2518 Salem St.

15- Robert P. Harrison, ..., 191.....

MAR 21 1921 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 20, 1921, to, Mar 21 1921, that I saw h~~im~~ alive on Mar 20 1921, and that death occurred, on the date stated above, at 12M m.

The CAUSE OF DEATH* waa as follows:

Cholera Infantum

..... (Duration) yrs. — mos. 1 ds.

Contributory (SECONDARY) .....

..... (Duration) yrs. ..... mos. ..... ds.

(Signed), Fred Talbott M. D.

Mar 21 1921 [Address] 1353 W Fayette

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, If not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Laurel Cem	3 22 1921
20-UNDERTAKER	ADDRESS
[illegible]	[illegible]

WHITE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If [illegible] state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.52114 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.52114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 37 Quay Alley. ST. 22 WARD) 91 REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel Gales. (C)

(Residence in Baltimore: No. 37 Quay Alley. St.: ~~yrs.~~, 3 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored.	Single

6-DATE OF BIRTH, December 10th. 1920, 1 (Month) (Day) (Year)

7-AGE, ~~yrs.~~ 3 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. gd
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry Brown. (C)

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Mamie Gales. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Gales. (C) mother

(Address) 37 Quay Alley.

15- Robert P. Harrison, Registrar.

Filed ....., 191.... Burial Permit Issued .....

MAR 21 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 14th. 1921, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
unknown.

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Fernbach M. D. (Coroner.)

March 17 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 19....
20-UNDERTAKER Commissioner Health,	ADDRESS MAR 21 1921

Morgue

Per Wm. E. WOODALL

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Where CAUSE OF DEATH is very important, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.52115 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.52115

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor Bronlett

(a) RESIDENCE. No. 903 East St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 11 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe Fitter 54 05

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Seattle, (State or country) Washington.

PARENTS

10 NAME OF FATHER John Bronlett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Mary Wrensick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed MAR 21 1921, 19 Registrar Burial Permit Clerk.

N.B.—WRITE PLAINLY, WITH LINK. Physicians should be stated EXACTLY. PHYSICIAN'S AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 11, 19 21 to March 17, 19 21 that I last saw h im alive on March 17, 19 21 and that death occurred, on the date stated above, at 7:05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) V Bierman, M. D.

3/17/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: MAR 21 1921

20 UNDERTAKER: Commissioner Health, (ADDRESS) Per Wm F. WOODALL

Spec.—6-9-19—H. P. Co.—1000 Eks.

D.52116 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52116

CERTIFICATE OF DEATH.

REGISTERED NO. 1537

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Farnandis.

(a) RESIDENCE. NO. 3057 N. North Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Farnandis

6 DATE OF BIRTH (month, day, and year): July-4-1859

7 AGE: Years 61 Months 8 Days 16 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager

(b) General nature of industry, business, or establishment in which employed (or employer): [redacted]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Walter Farnandis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: ? Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant: Mrs. Emma Farnandis

(Address): 3057 N. North Ave

15 Filed ..... 19 Robert P. Garrison, Registrar

MAR 21 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-20 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-4-21, 19..., to 3-20, 1921, that I last saw him alive on 3-20, 1921, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

General Paresis

Lues

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ....yrs. ....mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. C. Crane, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: March 22 1921

20 UNDERTAKER: Wm. J. Gichner Sons

ADDRESS: Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PROFESSIONAL TERMS should be avoided. All information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52117 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52117

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Sargeant ST.: V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Williams

(a) RESIDENCE. No. 512 S. Linthicum ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Williams ~~Dec~~

6 DATE OF BIRTH (month, day, and year) July 14-1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bar tender

(b) General nature of industry, business, or establishment in which employed (or employer) Oliver

(c) Name of employer Mr Louis Otto Balto Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Hezakiha Williams

11 BIRTHPLACE OF FATHER (city or town) Cumberland Md (State or country)

12 MAIDEN NAME OF MOTHER Laura Mosher

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. Eva Williams (Address)

15 Filed ....., 19..... Robert P. Harrison, Registrar

MAR 21 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1919, to Mar 20, 1921, that I last saw h[illegible] alive on Mar 19, 1921, and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Haemorrhage

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 3 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. E. Harden, M. D.

Mar 22 1921 (Address) 1201 N Pat Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL, CREMATION~~ OR REMOVAL	DATE OF BURIAL
Frostburg Md	Mar 22 1921
20 UNDERTAKER	ADDRESS
Wm J Tuckers Sons	N & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.52118 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.52118

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: CITY OF BALTIMORE (No.) 1635 Poplar Grove St. (St.) 15 (Ward) 43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Grimaldo

(a) RESIDENCE. No. 1635 Poplar Grove St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Jefferson D. Grimaldo

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE — Years: 48 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John W. Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto - Md

14 Informant (Address): Jefferson D. Grimaldo 1635 Poplar Grove St

15 Filed 19 Robert P. Harrison, Registrar

MAR 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1918, to Mar. 18, 1921, that I last saw h M alive on Mar. 18, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cancer [redacted] (General)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(duration) 2 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 1918

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) [illegible] M. D.

3/3, 1921 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	3/22 1921
20 UNDERTAKER	ADDRESS
John J Tobey Sons	1318 Light St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D.52119

D.52119

1926
71
1873

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 834 E Preston ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget A. Kelly

(a) RESIDENCE. NO. 834 E Preston ST. 1st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawrence J. Kelly

6 DATE OF BIRTH (month, day, and year) Dec. 27, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland (State or country)

PARENTS

10 NAME OF FATHER Thomas Costello

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McGowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Kelly (Address) 834 E Preston St.

15 Filed Mar 21 1921 Robert P. Harrison, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to Mar 21, 1921, that I last saw him alive on March 20, 1921, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Faulconer, M. D.

3/21 1921 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Mar 23 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	783 Hanover

mation should be carefully supplied. Exact statement OCCUPA-
it may be properly classified.
CAUSE OF DEATH in plain terms, so that it ma
TION is very important. See instructions on ba
on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52120 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52120

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Home of Aged, Franklin & Fulton (St.;) 10 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Bell Young

(a) RESIDENCE. No. Home of Aged St. Franklin & Talbot Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14. - 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md. Balto

PARENTS

10 NAME OF FATHER John W. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Sees

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ettie Cuddy

(Address) 400 N. Fulton Ave.

15 Filed Mar 21 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar- 1- 1921, to Mar 20 1921, that I last saw h[er] alive on Mar- 19 1921, and that death occurred, on the date stated above, at 11. PM m.

The CAUSE OF DEATH* was as follows:

Cerebral softning with left side hemi plegia, with complications ?

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Gradual mental and physical decline (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jarsley Cole M. D.

3/21. 1921 (Address) 702 Goodson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem — DATE OF BURIAL Mar. 22 1921

20 UNDERTAKER Geo J. Smith — ADDRESS 1000 W. Fayette St

R21 1921

mation should be carefully [illegible]. Any [illegible] that it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Burnes)

D.52121

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52121

CERTIFICATE OF DEATH.

10-119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 45 N. Caroline St.; 6 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Barnes

(a) RESIDENCE. No. 145 N. Caroline St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 16 - 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	-	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) - 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md. Md. U.S.

PARENTS

10 NAME OF FATHER George Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant

(Address) 45 N. Caroline St

15 Filed MAR 21 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to March 19, 1921, that I last saw h[illegible] alive on March 19, 1921, and that death occurred, on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza Families

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) J. W. Robinson, M. D.

3/21, 1921 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 23 1921
20 UNDERTAKER	ADDRESS
J. W. Henry Smith	1810 Argyle Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. Any

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52122 HEALTH DEPARTMENT—CITY OF BALTIMORE D52122

CERTIFICATE OF DEATH. 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6005 Hendrix Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Rebecca Tudor

(a) RESIDENCE. No. 6005 Hendrix Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: John R. Tudor

6 DATE OF BIRTH (month, day, and year): June 26 1898

7 AGE: Years 22 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: David Shannon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary F. McClelland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): John R Tudor 6005 Hendrix Ave

15 Filed MAR 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1921, to March 20 1921, that I last saw h... alive on March 18 1921, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) Emma C. Lamont M. D.

March 21 1921 (Address) 928 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	March 23 1921
20 UNDERTAKER	ADDRESS
Wm Cook.	8 + Dolphin St.

information should be carefully supplied. AGE should be stated EXACTLY. If the deceased was a child or a woman CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52123 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52123

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4 (Street) Jackson Ave (Ward) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Townsend

(a) RESIDENCE. (Usual place of abode) No. 4 Jackson Ave ST., 27 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Frederick Townsend

6 DATE OF BIRTH (month, day, and year): Oct 24, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic Duties At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William Townsend

(Address) 4 Jackson Ave. Raspeburg

15 Filed ....., 19.... Robert P. Harris Registrar

MAR 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1921, to Mch. 21, 1921, that I last saw her alive on Mch 20, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross pathological

(Signed) Chas. A. L. Wilkinson, M. D.

, 19 (Address) Raspeburg, Balt. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3/23 19
20 UNDERTAKER: William Cook.	ADDRESS: 501 E North

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D.52124 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52124

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 219 Monastery ave St.: 70 1/20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Herbert

(Residence in Baltimore: No. 218 Monastery ave St.; yrs., 16 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, May (Month) 1 (Day), 1871 (Year)

7-AGE, 49 yrs. 10 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private 69

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joseph Herbert

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Thresa Schandberger

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosalie Herbert

(Address) 218 Monastery ave

15- Robert P. Harrison,

....., 191..... Registrar.

Burial Permit [illegible]

MAR 21 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Nephritis Interstitial

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Convulsions

(Duration) Sudden yrs. mos. ds.

(Signed) James W Fenton (Coroner.) M. D.

Mar 20 1921 (Address) 207 Church

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	March 23 1921
20-UNDERTAKER	ADDRESS
Wm Cook	1424 Mon

9.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52125 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52125

CERTIFICATE OF DEATH.

10-091

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 3236 Cedar Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle Stumpf

(a) RESIDENCE. No 3236 Cedar Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write this word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Joseph Stumpf

6 DATE OF BIRTH (month, day, and year) March 22 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Olsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Chatman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant M. L. F. Stumpf (Address) 3236 Cedar Ave

15 Filed 1921, 19 Robert P. Harris, Registrar

R2 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1921, to March 20, 1921, that I last saw h.r alive on March 20-1921, and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

Grippe (duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Grippe (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J Davies, M. D.

3/21 1921 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 25 1921
20 UNDERTAKER	ADDRESS
W. Bleat	502 E Monta

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52126 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N. Fremont Ave ST.: 4 WARD) 79 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Stengel

(a) RESIDENCE. No. 213 N. Fremont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of ~~or~~ WIFE of Mamie R Stengel

6 DATE OF BIRTH (month, day, and year) unknown 1866

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman 086

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mamie R Stengel
(Address) 2134 Fremont St

15 Filed Mar 1921 Robert F. Harrison, Registrar
Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to Mar 19, 1921, that I last saw him alive on Mar 19, 1921, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Roentgen Ray

(Signed) Wm G Hoag, M. D.

3/21, 1921 (Address) 1 E Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Back Cemetery	Mar 22 1921

20 UNDERTAKER Robt J Turner Inc ADDRESS 1717 Druid

mation should be carefully supplied. AGE should be stated
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

D.52127

D.52127

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3203 Westwood ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A Sampson

(a) RESIDENCE. NO. 3203 Westwood ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Sampson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Sophia Fritz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John J. Sampson
(Address) Catonsville Md

15 Filed 19 Robert P. Harrison, Registrar

MAR 21 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1921, to Mar. 20, 1921, that I last saw h.r alive on Mar. 20 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Hypertension (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) ? yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual Clinical Tests

(Signed) Samuel Robinson M. D.

, 19 (Address) 2444 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 22th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	112 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52128

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52128

CERTIFICATE OF DEATH.

79-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 N. Eden ST.: B WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy A. Burnitt

(a) RESIDENCE. NO. 116 N. Eden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) May 30th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William Burnitt

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Jane Guest

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Miss Mary E Burnitt
(Address) 116 N Eden st

15 Robert P. Harrison, 19
Registrar
Burial Permit Clerk.

R 21 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10. 1921. to March 19. 1921.

that I last saw her alive on " " 1921,

and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH was as follows:

Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchia Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Okarr M. D.

3/21. 1921 (Address) 2600 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 23 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52129

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52129

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 N. Central ave ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Kieffner

(a) RESIDENCE. NO. 729 N. Central ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Elizabeth Kieffner

6 DATE OF BIRTH (month, day, and year) August 14th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabnet Maker 01

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Kieffner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Philip Kieffner
(Address) 2022 E 21st st

15 [illegible] P. Harrison, Registrar

APR 21 1921

[illegible] Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to March 20, 1921, that I last saw h[illegible] alive on March 19, 1921, and that death occurred, on the date stated above, at 10.25 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Influenza Lagrippe

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David E. Elliott, M. D.

March 21, 1921 (Address) 928 N. Central ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Mar. 22nd 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

MARBLE EARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52130 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52130

CERTIFICATE OF DEATH. 138

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 N. Wolfe ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Robinson

(a) RESIDENCE. No. 1018 N. Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of John Robinson

6 DATE OF BIRTH (month, day, and year) Jan. - 1887

7 AGE	Years	Months	Days	If LESS than 1 day ...hrs. or ...min.
	34	2	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John T Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary Gregory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14. Informant John Robinson (Address) 1018 N. Wolfe St

15 Filed ... Robert P. Harrison, Registrar

MAR 21 1921

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1921

17

I HEREBY CERTIFY, That I attended deceased from 2/17, 1921, to 3/20, 1921, that I last saw her alive on March 19, 1921, and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Puerperal eclampsia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. M. B. Robinson, M. D.

3/20 1921 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn 3/22/21 DATE OF BURIAL 19

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and undertaker's name and address must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 52131 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52131

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2619 Maryland Av ST.: 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Saranda L. Baughman

(Residence in Baltimore: No. 2619 Maryland ave St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, August 12, 1838.
(Month) (Day) (Year)

7-AGE, 82 yrs. 7 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) ..... NO

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Jacob Slagen

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Dortha Haury

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dominick L. Burke

(Address) 2619 Maryland Ave.

15-

Robert P. Harrison,

Filed ....., 191.....

AR 21 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 19 1921, to March 21 1921, that I saw her alive on March 20 1921, and that death occurred, on the date stated above, at 2 40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. F. Robinson M. D.

3/21, 1921, (Address) 1307 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Freedom Pa — DATE OF BURIAL, Mar 25, 1921.

20-UNDERTAKER A. D. Marshall — ADDRESS 3539 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052132

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52132

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2002 Plymouth Ave (ST.) 13 (WARD)

2-FULL NAME Mary Kelby

(a) RESIDENCE. No. 2002 Plymouth Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Phillip Kelby

6 DATE OF BIRTH (month, day, and year): June 17 1879

7 AGE — Years: 41 — Months: 9 — Days: 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Thomas Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Canada

12 MAIDEN NAME OF MOTHER: Catherine Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant (Address): Phillip Kelby 2002 Plymouth Ave

15 Filed ..... 19 ..... Robert P. Harrison Registrar

MAR 21 1921 Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30 1921, to March 20, 1921, that I last saw h.. alive on March 19, 1921, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pleurisy abscess

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Typical Signs

(Signed) C. Houghton M. D.

3-21-1921 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden — DATE OF BURIAL: Mar 22 1921

20 UNDERTAKER: A J Marshall — ADDRESS: 3539 Falls Rd

MARION BOARD OF CERTIFY SUPPLIED. ALL ITEMS SHOULD BE STATED EXACTLY. TYPEWRITING SHOULD BE USED. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52133 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52133

CERTIFICATE OF DEATH. † 28-010

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 7002 Plymouth Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. Kelby

(a) RESIDENCE. No. 7002 Plymouth ST., WARD. ? Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 28, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Hand Cotton

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Mills

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mich.

PARENTS

10 NAME OF FATHER Phillip Kelby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mich.

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Phillip Kelby (Address) 7002 Plymouth Ave

15 Filed Robert P. Harrison, Registrar

MAR 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1921, to Mar. 21, 1921, that I last saw him alive on March 20, 1921, and that death occurred, on the date stated above, at 3 9, m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Lymphosa

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Typical signs

(Signed) Chas. Hubschmitt, M. D.

3/21/1921 (Address) 3201 Orland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Mar. 22 1921

20 UNDERTAKER St Mary Hall 3539 Frankford Ave ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52134

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52134

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1923 W. Fairmount Ave. ST.: 20 WARD)

2-FULL NAME Melvin LeRoy Vessel

(a) RESIDENCE. No. 1923 W. Fairmount Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy. Gld

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. E. Vessel

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Mary M. Hoffman Stull

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant George Vessel
(Address) 1923 W. Fairmount Ave

15 MAR 22 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 19, 1921, that I last saw him alive on March 19, 1921, and that death occurred, on the date stated above, at 1:55 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Geo. E. Wissing, M. D.

3/19, 1921 (Address) 2002 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Mar 22 '21
20 UNDERTAKER	ADDRESS
Joseph L. B. Cook	1003 W. Balto St

mation should be carefully supplied. Avoid abbreviations. Write plainly in ink. Exact statement of OCCUPATION should be made, that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52135

142

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Warner ST.: 21 WARD)

2-FULL NAME Henry Carey

(a) RESIDENCE. NO. 1011 Warner ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella Carey

6 DATE OF BIRTH (month, day, and year) 3/1/1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&O

(b) General nature of industry, business, or establishment in which employed (or employer) Oysterhouse

(c) Name of employer Joshua Oysters

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Maggie White

(Address) 1011 Warner St.

15 Filed MAR 22 1921 ROBERT A KRAUTER Registrar

Burial Form'l Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/9/21, 19..., to 3/20, 1921, that I last saw him alive on 3/20/21, 19..., and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Ringworm of Foot (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ruf Fowley, M. D.

3/21/21 (Address) 908 S Stiles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cet.	May 22 1921
20 UNDERTAKER	ADDRESS
Isaiah L. Bowyer Son	1054 W Monty. St.

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. PHRASEOLOGY OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52136

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3701 Springdale Ave ST. 15 WARD)

2-FULL NAME Jessie Landler Willard.

(a) RESIDENCE. NO. 3701 Springdale Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single, Married~~ Widowed, or ~~Divorced~~ (write the word) Widow.

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Josiah D. Willard.

6 DATE OF BIRTH (month, day, and year) Jan 14, 1845

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
76	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Villa Rica
(State or country) Ga

PARENTS

10 NAME OF FATHER Samuel Landler

11 BIRTHPLACE OF FATHER (city or town) Ga
(State or country)

12 MAIDEN NAME OF MOTHER Martha Beall

13 BIRTHPLACE OF MOTHER (city or town) Ga
(State or country)

14 Informant Samuel P. Landler
(Address) 3701 Springdale Ave

15 FILED MAR 22 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1912, to March 21 1921, that I last saw her alive on Mar 21, 1921, and that death occurred, on the date stated above, at 11 45 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility x. Coronal Artery Sclerosis. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leah L. Fetzer M. D.

3/21, 1921 (Address) 2806 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Atlanta Ga — DATE OF BURIAL Mar 22nd 1921

20 UNDERTAKER Bertram L. Gore — ADDRESS 1720 W. Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be plain terms, so that it may be properly classified. Exact statement of OCCUPATION may CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-52137

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D-52137

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Woodley ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Andrew Rawlins

(a) RESIDENCE. No. 1110 Woodley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Homer Rawlins

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Lacy Road

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

11 Informant Mrs. C. Rawlins.
(Address) 1110 Woodley Rd.

15 Filed MAR 22 1921, 19 ESTHER J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 19, 1921, to Mar 21, 1921, that I last saw h/m alive on Mar 20, 1921, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth
(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

3-21, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Peters Cemetery — DATE OF BURIAL: Mar 22 1921

20 UNDERTAKER: Bertram Boyle — ADDRESS: 1725 N. Fulton Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52138

CERTIFICATE OF DEATH

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Madison Ave. St. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin J. Auld

(a) RESIDENCE. No. 1404 Madison Ave. STR. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Emma Auld

6 DATE OF BIRTH (month, day, and year) Oct. 19-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Broker

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Balto.

PARENTS

10 NAME OF FATHER Hobbsmay Auld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Nancie Virginia Lefford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Emma Auld

(Address) 2246 Baker St

15 MAR 22 1921 EDWIN J. KRAUSS Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1920, to March 20th, 1921, that I last saw him alive on March 20th, 1921, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ant. portion of rectum with ulceration

(duration) yrs. 13 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes-Colostomy Date of March 7 '20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Illes, M. D.

(Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	March 22 1921
20 UNDERTAKER	ADDRESS
James Hyer	1407 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D52139

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52139

CERTIFICATE OF DEATH.

REGISTERED No. C 27 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4425 Braddock Ave St.; Forest Park WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unnamed 6 mos. Fortus Hamilton Wilson

(Residence in Baltimore: No. 4425 Braddock Ave St.; ... yrs., 6 mos. 6 days.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col	Single

6-DATE OF BIRTH, Mar 20, 1921.
(Month) (Day) (Year)

7-AGE, ... yrs. ... mos. ... ds.

If LESS than 1 day, 4 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... none
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Harry Wilson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Maye Walker

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Wilson

(Address) 4425 Braddock Ave

15- ROBERT I KRAUTH

Filed MAR 22 1921 191... Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 20, 1921.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar. 20 1921, to Mar. 20 1921, that I saw h[illegible] alive on Mar. 20 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

(a) Mus. Fetus Immature Birth due to Maternal Causes. (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) S. Mother has Gr. Pneumonia (Duration) ... yrs. ... mos. ... ds.

(Signed) W. J. Carr M. D.

Mar 21, 1921. (Address) 715 Mosher St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	3/22, 1921
20-UNDERTAKER Mrs Root a Elliott	ADDRESS 1725 Eastland Ave

N.B.—Every item of information should be carefully supplied. ACCURACY should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52140 John Grady D52140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 68 S Carrollton av ST.; 18 WARD)

REGISTERED No. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Grady

(a) RESIDENCE. No. 68 S Carrollton av ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) July 20th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Rose 86

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Grady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Bridget Grady

(Address) 68 S Carrollton av

15 Filed MAR 22 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1921

17

I HEREBY CERTIFY, That I attended deceased from July, 1919, to Mar 21, 1921, that I last saw him alive on Mar 20, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Int. Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dyspnea

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3/31, 1921 (Address) 1302 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 24 1921

20 UNDERTAKER John J Stride ADDRESS 1200 N Fremont

mation should be carefully supplied. Age, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(See affidavit over)

D52141 HEALTH DEPARTMENT—CITY OF BALTIMORE D52141

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Falls Road & Belvedere St.; 27th WARD) REGISTERED No. C 175-107

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Gustin.

(Residence in Baltimore: No. 700 Woodbourne Ave Govans St. Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, March 29 (Month) (Day), 1900 (Year)

7-AGE, 20 yrs. 11 mos. 20 ds. (3) If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): B & O

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Harry R. Gustin

11-BIRTHPLACE OF FATHER (State or Country), Ohio.

12-MAIDEN NAME OF MOTHER Maud R. Ritchey.

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry R. Gustin

(Address) 700 Woodbourne Ave

15- Filed MAR 22 1921 191... ROBERT J. KRAUTH Registrar. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to *his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull & Internal injuries

Automobile Accident

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John [illegible] M. D. (Coroner.)

March 21, 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Blanchester Ohio	3/23/21 19....
20-UNDERTAKER William Cont.	ADDRESS 562 E. North Ave

3/20/21 Mooney 3632 Roland Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Fractional parts of a day, in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Baltimore, Md., March 30, 1921.

I do hereby make oath that the age given on Baltimore City Certificate of Death D-52141 as 20 years, 11 mos., 20 days, is not correct; that same should be 20 years, 3 mos., and 20 days. Name of deceased - Margaret Gustin.

J. R. Gustin

Father.

Subscribed and sworn to before me this 30th day of March, 1921

Reed Gaither

Notary Public.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52142

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 N. Charles St. ST.: 11 WARD)

2-FULL NAME Nellie Bland Appold Adams

(a) RESIDENCE. NO. 1314 N. Charles St. ST., 11 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? 51 yrs. 1 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr. J. Fred. Adams.

6 DATE OF BIRTH (month, day, and year) Feb-3-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: George J. Appold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Sarah Mackenzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Dr. J. Fred. Adams (husband)

(Address) 1314 N. Charles St.

15 Filed MAR 22 1921 ROBERT A. KRAUTER Registrar

Burial Permit Obtd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1921, to March 21, 1921, that I last saw h-- alive on March 21, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

& Bronchial Glands & Metastasis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Nephritis —

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination of Mass

(Signed) C. H. McGuire, M. D.

, 19 (Address) 415 Lexington ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Mar-23-1921

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 106 W. NORTH AVE.

NOTE.—PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52143 HEALTH DEPARTMENT—CITY OF BALTIMORE D52143

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Callahan (a Martina)

(a) RESIDENCE. No. Mt Hope Retreat ST., 28 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? Not Known yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	27	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious - 065

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Cornelius Callahan

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Healy

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Ireland -

14 Informant Records of Mt Hope Retreat (Address)

15 Date MAR 22 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17 I HEREBY CERTIFY, That I attended deceased from January, 1921, to March 21, 1921, that I last saw h[illegible] alive on March 20, 1921, and that death occurred, on the date stated above, at 5.10 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Chronic -

Abt (duration) 4 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Emmitsburg Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Lamury, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hope Cemetery	Mar 22, 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052144

HEALTH DEPARTMENT—CITY OF BALTIMORE

052144

CERTIFICATE OF DEATH.

REGISTERED NO. 1092

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospl. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Linwood Bauks

(a) RESIDENCE. No. 86 Callender St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Grauley Bauks

6 DATE OF BIRTH (month, day, and year) Nov 30th 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	3	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Balto Tube works
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimd

PARENTS

10 NAME OF FATHER Franklin Bauks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Ladloo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Margaret Bauks
(Address) 86 Callender St.

15 Filed MAR 22 1921 19 Burial Permit Given Egbert I Krauter Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/17/ 1921, to 3/19/21, 19....,
that I last saw h.... alive on 3/19/21, 19....,
and that death occurred, on the date stated above, at 11 30P m.
The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Indigestion
(duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 3/19/21

Was there an autopsy? No

What test confirmed diagnosis? by operation

(Signed) Richard Dorsey, M. D.

, 19 (Address) 117 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Grave	Mar 23rd 1921

20 UNDERTAKER John J Cowan & Son — ADDRESS 901 Hollins St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D52145 HEALTH DEPARTMENT—CITY OF BALTIMORE D52145

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 151

CITY OF BALTIMORE (No. 2022 Alicanna ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Fisher

(Residence in Baltimore: No. 2022 Alicanna St.; 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 7th, 1921
(Month) (Day) (Year)

7-AGE, ——yrs. ——mos. 14 ds. If LESS than 1 day, ~~hrs.~~ or ~~min.~~?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Child

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Jacob Fisher

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary Walden

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Fisher

(Address) 2022 - Alicanna

15- Filed MAR 22 1921 191 ROBERT B KRAUTER Registrar.
Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Westgate (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Oliver Lyon Westgate M. D.
(Coroner)
3/22, 1921 (Address) 1800 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Pauls Cemetery	3/22/21, 19...
20-UNDERTAKER Geo J. Ruth	ADDRESS 1735 Harford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

252146 HEALTH DEPARTMENT—CITY OF BALTIMORE 252146

CERTIFICATE OF DEATH.

156-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4331 E. Lombard Street St.: 26 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Meehan

(Residence in Baltimore: No. 4331 E. Lombard Street St.; 20 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, UNKNOWN (Month) (Day), 1851 (Year)

7-AGE, 70 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Meat Packer
(b) General nature of industry, business, or establishment in which employed (or employer): Meats

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Dan Meehan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Baltimore St.

15- MAR 22 1921 ROBERT J. KRAUSE

Filed....., 191.... Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20/ 1921, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

3/21, 191 (Address) 1 E. o Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. mos. ds. In the State 20 yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	5/23, 1921
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E Balt St

Lila Lipsey

D52147 HEALTH DEPARTMENT—CITY OF BALTIMORE D52147

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fusterton Road & Katonst ST.: 11 WARD) 15-001

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Lila Lipsey

(Residence in Baltimore: No. 1312 N. Charles st St.; yrs. 12 mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1894 (Year)

7-AGE, 27 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Indiana

PARENTS.

10-NAME OF FATHER, Dr. F. W. Welch

11-BIRTHPLACE OF FATHER (State or Country), Indiana

12-MAIDEN NAME OF MOTHER Emma Hazzard

13-BIRTHPLACE OF MOTHER (State or Country), U.S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Balto

15-

MAR 22 1921 191.....

ROBERT E KRAUTER
BURIAL PERMIT Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) must find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage
and auto-collision
(accident)
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Mar 22, 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew — DATE OF BURIAL, 3-22, 1921

20-UNDERTAKER Jack Lewis, 1411 E. Balto — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D52148 Daniel O Russell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52148

CERTIFICATE OF DEATH.

X 28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 12 W. Preston ST.: 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME D. O. Russell

(Residence in Baltimore: No. 12 W. Preston St.; yrs., 1 mos. ds.)

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 26, 1853 (Month) (Day) (Year)

7-AGE. 67 yrs. 7 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cutter
(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, R. Russell

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mulvey

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Russell

(Address) 12 W. Preston

15-MAR 22 1921 ROBERT E CRAUTER

Filed....., 191.... Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Hemorrhage

Probably tubercular

(b) Coughing 8 or 9 mos. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mackey M. D. (Coroner.)

March 21, 1921. (Address) 1937 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 mos. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Bon Secours

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, March 23, 1921

20-UNDERTAKER Chr. Wilson & Son

ADDRESS 2503 Edmondson

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52149 HEALTH DEPARTMENT—CITY OF BALTIMORE D52149

CERTIFICATE OF DEATH.

REGISTERED NO. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 E Preston ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Magness

(a) RESIDENCE. No. 1206 E Preston ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced (write the word)~~
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Moses Nathaniel Magness

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant H. Lee Magness MD (Address) 1206 E Preston St

15 MAR 22 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1921, to March 21, 1921, that I last saw her alive on March 21, 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Infirmities of age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1206 E Preston

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) R. O. Carman, M. D.

3-21-1921 (Address) 1707 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	3/24 1921

20 UNDERTAKER Chas F. Evans & Son ADDRESS 1180 W. Mt Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52150

CERTIFICATE OF DEATH.

91-081

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Crittenden C. Fowler

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Venona Fowler

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Jesse Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Lauder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed MAR 22 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 19 21

17

I HEREBY CERTIFY, That I attended deceased from April 28, 19 20, to March 19, 19 21, that I last saw him alive on March 19, 19 21, and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) [illegible] M. D.

3/21/21 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Cem	3/22 '21
20 UNDERTAKER	ADDRESS
Chas F. Ware & Son	1180 W. Mt Royal Ave

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If LESS than 1 day, HOURS or MINUTES. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

952151

HEALTH DEPARTMENT—CITY OF BALTIMORE

952151

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 569 Dolphin St. ST.: 17 WARD)

2-FULL NAME Sarah Ashley

(a) RESIDENCE. No. 569 Dolphin St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? b/n yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Abt 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Centreville Queen Anne's Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Mary Diggs
(Address) 569 Dolphin St

15 MAR 22 1921 ROBERT A. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20 — 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14th 1921, to March 18th 1921, that I last saw h[illegible] alive on March 19th 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paralysis

OVER

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas A Dayton, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL Mar 23 1921

20 UNDERTAKER Samuel P Hensley

ADDRESS 678 W Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal cerebral hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52152

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52152

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3514 Cottage Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Zulauf

(a) RESIDENCE. NO. 3514 Cottage Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of the late Lewis Zulauf

6 DATE OF BIRTH (month, day, and year) Sept 20 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mr Wellington H. Zulauf
(Address) 3514 Cottage Ave

15 Filed MAR 22 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to March 21, 1921, that I last saw her alive on March 20, 1921, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Ephecrosion

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Alls Bagg, M. D.

, 19 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 23 192
20 UNDERTAKER Henry Hoeck Son	ADDRESS 1301 E Eager

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52153

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52153

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Curley St.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Reisig

(a) RESIDENCE. No. 412 N. Curley St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Louise

6 DATE OF BIRTH (month, day, and year) Feb. 5, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	15	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Battler

(b) General nature of Industry, business, or establishment in which employed (or employer) Shark & Johnson

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Christian Reisig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant John C. Reisig
(Address) 412 N. Curley

15 Filed MAR 22 1921, 19 ROBERT F. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 20 1921

I HEREBY CERTIFY, That I attended deceased from Mar 15, 1921, to Mar 20, 1921.

that I last saw h~~im~~ alive on Mar 19, 1921.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter Waller White M.D.

3/21, 1921 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Mch 23 1921
20 UNDERTAKER Kirkler & Kirkler	ADDRESS 1739 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D52154 HEALTH DEPARTMENT--CITY OF BALTIMORE D52154

CERTIFICATE OF DEATH

1 PLACE OF DEATH — Registered No. C 170

CITY OF BALTIMORE (No. 1832 Harford ave ST. 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Brimmel

(Residence in Baltimore: No. 1832 Harford ave St.: 43 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH: March 7th (Month) (Day), 1836 (Year)

7-AGE: 85 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Georg Brimmel

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Katherine Rausch

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. F. Abeles

(Address) 1830 Harford Ave.

15- Filed MAR 22 1921 SCHEET E KRAUYER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to March 21 1921, that I saw him alive on March 21, 1921, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) yrs. mos. ds

Contributory (SECONDARY) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Geo Dorsey M. D.

March 22, 1921. (Address) 1107 Jefferson Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Back County — DATE OF BURIAL: March 24 1921

20-UNDERTAKER: Geo Lauenbach — ADDRESS: 647 W Pratt S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Nan E. Magee

D52155 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D52155

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 801 E 41st St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nan E Magee

(a) RESIDENCE. No. 801 E 41st St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Edwd. V

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Agnes McNally

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Agnes Magee
(Address) 801 E. 41st St

15 Filed ....., 19 ..... Registrar

MAR 22 1921

ROBERT J. KRAUSE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1920, to March 20, 1921, that I last saw her alive on March 20, 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum Physician

(Signed) Walter A Lee, M. D.

3/21/1921 (Address) 531 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	3-23 1921
20 UNDERTAKER	ADDRESS
H. B. Flamming Son	517 N. Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

52156

HEALTH DEPARTMENT—CITY OF BALTIMORE

52156

92-170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Volunteers of Am. Hosp. REGISTERED NO.....

CITY OF BALTIMORE: (No. 418 W. Lexington ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rena Albertie Doster

(a) RESIDENCE. No. 332 S. Bruce ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. H. Doster

6 DATE OF BIRTH (month, day, and year) Jan. 22, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32.	1	26.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co., (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Creswell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha A. Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Geo. H. Doster

(Address) 332 S. Bruce St

15 Filed MAR 22 1921 ROBERT J. KRAUSER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20-1921

17 I HEREBY CERTIFY, That I attended deceased from 3-16, 1921, to 3-20, 1921, that I last saw her alive on 3-20, 1921, and that death occurred, on the date stated above, at 8.35 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 332 S. Bruce

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diag-

(Signed) J. [illegible] Cavanaugh, M. D.

, 19 (Address) 418 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Mar 22 1921
20 UNDERTAKER Harry H. Witzke	ADDRESS 1531 W Fayette

mation should be carefully supplied. Avoid abbreviations. Write out each word. Do not use ditto marks. Unless CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

952187

HEALTH DEPARTMENT—CITY OF BALTIMORE

952157

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST.: 19 WARD)

2-FULL NAME Geo. H. Manfield

(a) RESIDENCE. NO. 501 E. ~~Eutaw~~ Fulton Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie B. Manfield

6 DATE OF BIRTH (month, day, and year) June 15, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55 yrs	9?	5?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Blower ~~Do not know~~ 88

(b) General nature of industry, business, or establishment in which employed (or employer) Glass Blower

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany "

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany "

14 Informant Mrs. Jennie Manfield
(Address) 501 E. Balto. Ave

15 FILED MAR 22 1921 [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-27, 1921, to 3-20, 1921, that I last saw h[illegible] alive on 3-20, 1921, and that death occurred, on the date stated above, at 10 45 A.M.

The CAUSE OF DEATH* was as follows:

Dyspnea Laryngea
Retrosternal
Bronchostenosis Gland.
Thyroid Cyst (duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure (duration) yrs. 18 hrs mos.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. W. Ordway, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 23 1921
20 UNDERTAKER Harry H. Witzke	ADDRESS 1531 W. Lombard St.

INFORMATION IS ABSOLUTELY REQUIRED. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52188 Most

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1328 Harford Ave St.: 9 Ward)

REGISTERED NO. 28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Most

(a) RESIDENCE. No. 1328 Harford Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? 71 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Clara Most

6 DATE OF BIRTH (month, day, and year) Dec 20, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Most

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha A Rawlings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Walter C Bacon 100 E 20th St

15 MAR 22 1921 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to March 21, 1921, that I last saw him alive on March 21, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. + mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) Walter C Bacon, M. D.

3/21 1921 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 24 1921
20 UNDERTAKER	ADDRESS
Josiah Depue	1666 W Mulberry

mation should be carefully supplied. Arts. [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52159 HEALTH DEPARTMENT—CITY OF BALTIMORE D52159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 41 Maryland ave ST. Westport 25th WARD)

REGISTERED No. 64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Elizabeth Hann

(a) RESIDENCE. No. 41 Maryland Ave ST. 25th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late John B Hann

6 DATE OF BIRTH (month, day, and year): May 26, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Carterton U.S.

PARENTS

10 NAME OF FATHER: Issac Garrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carterton U.S.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Sarah Hann
(Address) 41 Maryland Ave

15 Filed MAR 22 1921 ROBERT B. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1921, to Mar 20, 1921, that I last saw h... alive on Mar 20, 1921, and that death occurred, on the date stated above, at 4.25 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) H Laurence Wheeler M. D.

, 19 (Address) Cleveland Rawlings Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodland Union Cemetery Md	March 23 1921

20 UNDERTAKER: Sarah Hann ADDRESS 1600 N North Ave

mation should be carefully supplied. Any statement which CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Brown

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-52160

D-52160

10-07

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207- 20½ ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Brown

(a) RESIDENCE. NO. 207- 20½ ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Brown.

6 DATE OF BIRTH (month, day, and year) March 15-1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Boiler Washer.

(c) Name of employer B and O R. R.

9 BIRTHPLACE (city or town) (State or country) Greenville S. C.

PARENTS

10 NAME OF FATHER Andy Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greenville South Carolina

12 MAIDEN NAME OF MOTHER Lucretia Tom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greenville S. C.

14 Informant Bessie Brown

(Address) 207- 20½ Street

15 MAR 22 1921

ROBERT F. FRAZER
Registrar
Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 19 21

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1921, to Jan 21, 1921, that I last saw him alive on Jan 21, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Influenza -

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Otitis Media.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) William F. Wright, M. D.

March 23, 1921 (Address) 1209 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 24 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Ashby. 1

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-52161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-52161

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Barclay St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Perry Ashby

(a) RESIDENCE. No. 3206 Barclay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr. 1. 1919

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Warfield Ashby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Lula Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Warfield Ashby 3206 Barclay St

15 MAR 22 1921 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 21. 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 20 1921 to Mch 21 1921 that I last saw h alive on Mch 21 1921 and that death occurred, on the date stated above, at 5-P. m.

The CAUSE OF DEATH* was as follows:

Membranous Croup

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Garland Chunn M. D.

Mch 21, 1921 (Address) 1504 E. H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Mar 22 1921
20 UNDERTAKER	ADDRESS
George H. Hollang	1631 Druid Hill Ave

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. PLACE OF DEATH must be stated EXACTLY. OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52162

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 17 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cole, Mercy Hospital

(a) RESIDENCE. No. 305 E North Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 20-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Janitor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) a a

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Peter Johnson (Address) 1909 Dummore Ave

15 Filed MAR 22 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1921, to March 20, 1921, that I last saw h alive on March 20, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Peptic Ulcer Chronic Interstitial Nephritis

Probably several yrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & B Blood Smear

(Signed) J. O. Ridgely M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
York Co. Cem. York Town Va	Mar 23 1921
20 UNDERTAKER York R. R. Fun	ADDRESS
George H. Holland	1631 Druid Hill Ave

mation should be carefully supplied. Any [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

10 Aero

952163

HEALTH DEPARTMENT—CITY OF BALTIMORE

952163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Furley Ave Gardenville

CITY OF BALTIMORE: (No. 1 St.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fredk. Henry Peters

(Residence in Baltimore: No. Furley Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	S. single

6-DATE OF BIRTH. ..... March ..... 21 ..... (Month) (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 19 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Fredk Peters

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Hoffman

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fredk W. Peters

(Address) Furley Ave Gardenville

15- MAR 22 1921 191 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22 W.D.C., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 20 1921, to March 21 1921, that I saw h alive on March 21 191, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Convulsions

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm L Moore M. D.

....., 191... (Address) Gardenville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Trinity Cem	Mar 22, 1921
20-UNDERTAKER J Henry & Co	ADDRESS 2008 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

052164

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 E Preston ST.: 8 WARD)

2-FULL NAME Margaret Soffran

(a) RESIDENCE. NO. 2306 E Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Soffran

6 DATE OF BIRTH (month, day, and year) March 10, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	—	2	

8 OCCUPATION OF DECEASED At Home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany. Dont Know

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany. Dont Know

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna Johnson (Address) 2306 E Preston St

15 Filed MAR 22 1921 NOTED & FILED Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1921, to March 21, 1921, that I last saw h/W alive on March 20, 1921, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) B. O. Herzog M.D. M. D.

3/21, 1921 (Address) 1305 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Mar 23 1921

ADDRESS 2008 Aliceanna

20 UNDERTAKER J Herwig & Co

be properly classified. Exact statement of OCCUPATION should be carefully supplied. All items should be properly classified, so that it may be possible to compile accurate statistics. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52165

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52165

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Falls Road or Boloveau St. 12th WARD)

REGISTERED No. C 175-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Orlando R. Reese Jr

(Residence in Baltimore: No. 1625 N. Calvert St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
M	W.	Single

6-DATE OF BIRTH, Aug 4, 1900
(Month) (Day) (Year)

7-AGE, 20 yrs. 7 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Accountant
(b) General nature of industry, business, or establishment in which employed (or employer): Standard oil Co

9-BIRTHPLACE, (State or Country): Westminster Md

PARENTS.
10-NAME OF FATHER: Orlando R. Reese
11-BIRTHPLACE OF FATHER (State or Country): Westminster, Md
12-MAIDEN NAME OF MOTHER: Josephine Lynch
13-BIRTHPLACE OF MOTHER (State or Country): Westminster Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas F. Reese
(Address) 1625 Colvert St

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.
The CAUSE OF DEATH* was as follows: Fracture Skull and Internal Injuries Automobile accident
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) John Thomsen M. D.
(Coroner.)
Mar 21, 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Westminster, Md	3/23, 19.21
20-UNDERTAKER	ADDRESS
Henry W. Meas & Son	705 N. Calvert St

Via Western Md. R.R. Orlando R. Reese Jr mat

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D52166 HEALTH DEPARTMENT—CITY OF BALTIMORE D52166

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1634 St. Joseph Court ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doretha Ford

(Residence in Baltimore: No. 1634 St. Joseph Court St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col.	Boy

6-DATE OF BIRTH, Dec (Month) 18 (Day) 1919 (Year)

7-AGE, 1 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Ford.

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Pearl Washington

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Ford.

(Address) 1634 St. Joseph St.

15- Filed MAR 22 1921, 191.... ROBERT J. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 21 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

3-22-1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel.	Mar. 22 1921
20-UNDERTAKER	ADDRESS
Geo. E. Cook	North Harford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52167

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 Brewer ~~St~~ ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dyer

(a) RESIDENCE. No. 1127 Brewer St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard Dyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara Emery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Dyer

(Address) 1127 Brewer St

15 FILED MAR 22 1921 ROBERT J. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1920, to Mar 20, 1921, that I last saw him alive on Mar 19, 1921, and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? T.B.

(Signed) Frank E. Wagner, M. D.

Mar 21, 1921 (Address) 1006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 22 1921
20 UNDERTAKER	ADDRESS
David Earley	Pa ave 916

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52168 HEALTH DEPARTMENT—CITY OF BALTIMORE D52168

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Jackson

(a) RESIDENCE. No. 509 St. Mary's st. ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894 ??

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27 ??			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Thomas Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Martha Floyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records
(Address) M. T. H.

15 Filed MAR 22 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1921

17 I HEREBY CERTIFY, That I attended deceased from February 9, 1921, to March 18, 1921, that I last saw him alive on March 18, 1921, and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) C. S. Fahndrich, M. D.

3-18-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: MAR 22 1921

20 UNDERTAKER — ADDRESS

Commissioner Health

D52169

HEALTH DEPARTMENT—CITY OF BALTIMORE

1032 D52169

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1240 Mc Elderry St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Harnsleen

(Residence in Baltimore: No. 1240 Mc Elder St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1875 (Year)

7-AGE, 36 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Saloon
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Moses Harnsleen

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Balto. St.

15- Filed MAR 22 1921, 191..... ROBERT A. KRAUTER Clerk
Serial Form Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock. Acute Indigestion

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. F. Neilley M. D.
(Coroner.)

3-22, 1921. (Address) 99 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pikesville Cemetery	March 22 1921
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E. Balto.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stmr.—6-9-19—H. P. Co.—1000 Bks.

D52170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mrs. Carters Sanatorium 11 120 REGISTERED NO.

CITY OF BALTIMORE: (No. 907 Cathedral ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane H. King

(a) RESIDENCE. NO. 907 Cathedral ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Joseph King

6 DATE OF BIRTH (month, day, and year) July 16 1821

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	99	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin C Howard

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane G. Gilmor

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Richard H. Bayard
(Address) 907 Cathedral St.

15 Filed MAR 22 1921 ROBERT I. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1920, to March 21, 1921, that I last saw her alive on March 21, 1921, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. B. Hamman, M. D.

, 19 (Address) 1007 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	March 23 1921
20 UNDERTAKER	ADDRESS
A. W. Jenkins & Sons Co	Orchard & Paca Balto

mation should be carefully supplied. Avoid abbreviations. Give exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Dunner)

D.52171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52171

CERTIFICATE OF DEATH.

79-091

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Dunner

(a) RESIDENCE. NO. St. Joseph's Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mrs. Margaret Dunner
(Address) 122 N. Durham St.

15 Filed MAR 22 1921 Robert P. Harrison, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20/ 1921

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 20, 1921, that I last saw h Evalive on March 20, 1921, and that death occurred, on the date stated above, at 11:30P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) Chas O'Donovan, M. D.

, 19 (Address) 5. E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	March 23 1921
20 UNDERTAKER Lilly & Zirkin	ADDRESS 403 E Monument St

mation should be carefully supplied. Age should be stated in years, months and days if under one year. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D. 52172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52172

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3038 Elliott St. ST.; 1 WARD)

2-FULL NAME Elizabeth K. Linz.

(a) RESIDENCE. NO. 3038 Elliott St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 28-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Linz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Eva Hark.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant John Linz (Address) 3038 Elliott St.

15 Filed ..., 19 Robert F. Harrison, Registrar

MAR 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1st 1921, to March 20, 1921, that I last saw h[illegible] alive on March 20, 1921, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of heart (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) M J McAvoy, M. D.

, 19 (Address) 816 S. Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Mch. 23 1921
20 UNDERTAKER Lilly and Zuke	ADDRESS 403 S. Hoff

mation should be carefully supplied. Any blanks should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be of use in the preparation of certificates.
TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52173 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52173

CERTIFICATE OF DEATH. 109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3001 Elliott ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernadina Krauk

(a) RESIDENCE. No. 3001 Elliott ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frederick W. Krauk

6 DATE OF BIRTH (month, day, and year) Jun 14-1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Frederick W. Krauk
(Address) 3001 Elliott St

15 Filed ..... 19 Robert F. Harrison, Registrar

MAR 22 1921

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Mar 20, 1921, that I last saw her alive on Mar 19, 1921, and that death occurred, on the date stated above, at 1. a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Intussusception
Location unknown

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B Jackson M. D.

3/21, 1921 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Mar 23 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Pratt

Mation should be carefully supplied. Age should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52174 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52174

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 649 Bartlett Ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris V. Fahrman

(a) RESIDENCE. No. 649 Bartlett Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 28, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER William Fahrman

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Amal V. Wahlen

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant William Fahrman (Address) 649 Bartlett Ave

15 Filed MAR 22 1921 Robert F. Garrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21 21, to March 21 21, that I last saw her alive on March 21 21, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions.

due to Acute Enteritis.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Geo. Klingenstein Dia, M. D.

(Address) 401 E 25th St March 24/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	March 24 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	710 Fleet St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.52175 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52175

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 Riverside Av St.; 24 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula Emma Pickett

(Residence in Baltimore: No. 1509 Riverside Av St.; 45 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, Sept. (Month) 4 (Day), 1864 (Year)

7-AGE, 56 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, J. H. Slabaugh

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jennie Zollickoffer

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Silas C. Pickett

(Address) 1509 Riverside Ave.

15-

Filed ..... Robert P. Harrison Registrar.

MAR 22 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 20 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 19 1921, to Mar 20 1921, that I saw h[illegible] alive on Mar 20 1921, and that death occurred, on the date stated above, at 9.20 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral)

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Arteria - Sclerosis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Benj. F. Whitelow M. D.

Mar 21, 1921. (Address) 1929 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cemetery	Mar 24, 1921
20-UNDERTAKER	ADDRESS
C. J. Fanning Hon 1460	Battery Ave.

Permit Clark

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Franby 3522 Greenmount Ave

D.52176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Melville Ave ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrol Leroy Hopkins

(a) RESIDENCE. No. 621 Melville Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 12 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 000

(b) General nature of industry, business, or establishment in which employed (or employer) ... —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Robert F. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Hannah Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Robert F. Hopkins
(Address) 621 Melville Ave

15 Filed ..., 19.. Robert F. Harrison, Registrar

MAR 22 1921

Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1921, to March 21, 1921, that I last saw him alive on March 21, 1921, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

0000

Broncho-Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S. Franby, M. D.

19 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	3/23 1921
20 UNDERTAKER Wm Cook	ADDRESS N & G Ms

mation should be carefully supplied. Any information that it may be properly classified. Exact statement of OCCUPATION
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not premature
Child had bilateral
inguinal hernia No
infection prior to pneumonia

Spec.—8-24-14—M. & T.—2000 Bks.

(Laura)

10.52177

HEALTH DEPARTMENT—CITY OF BALTIMORE

10,52177

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Washington Road ST.; 2nd WARD)

Registered No. C 170

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lora L Deems

(Residence in Baltimore: No. Washington Road St.; 69 yrs., 1 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F.	W.	Widow

6-DATE OF BIRTH. Feb. 2, 1852 (Month) (Day) (Year)

7-AGE. 69 yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Killman

(Address) Washington Road

15-

Filed ....., 191.... Registrar.

APR 22 1921 Robert F. Garrison

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 10 1921, to March 22 1921, that I saw her alive on March 21 1921 and that death occurred, on the date stated above, at 8.50 m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis

(Duration) yrs. 2 mos. 1.0 ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 2½ ds.

(Signed) W B Hall M. D.

....., 191... (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Western Cemt DATE OF BURIAL, Mar 24 1921

20-UNDERTAKER W M Cook ADDRESS 5026 Natla

Burial Permit Clark.

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.52178 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.52178

CERTIFICATE OF DEATH.

812

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Trautner

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 21, 1921, that I last saw her alive on March 20, 1921, and that death occurred, on the date stated above, at 10:45 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary embolus.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) B Heuman, M. D.

3/21/21 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys - Hampden	March 23 1921
20 UNDERTAKER William Cook	ADDRESS 5022 E. North ave

MAR 22 1921

...mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... at it may be properly classified. Exact statement of OCCUPA- ... s on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52179 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52179

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 Lansing Ave ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Fink

(a) RESIDENCE. No. 1637 Lansing Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Fink

6 DATE OF BIRTH (month, day, and year) Jan 31 1874

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Freight Elevator

(b) General nature of industry, business, or establishment in which employed (or employer) Operator 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Fink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Helen B. Stoch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Catherine Fink
(Address) 1637 Lansing Ave

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

AR 22 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 1921

17

I HEREBY CERTIFY, That I attended deceased from July ....., 1920, to March 20, 1921, that I last saw h... alive on 2-5- 1921, and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Dissecting Aneurysm of Arch of Aorta:

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fluoroscopic Examination

(Signed) Harry Goldberg M. D.

3/21, 1921 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuel Cem Lauraville	3-23rd 1921

20 UNDERTAKER	ADDRESS
Mrs Chas A. G. Rohde	600 N Arlington Ave

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so

Spec.—5-19-13—M. & T.—500 Bks.

D.52180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52180

CERTIFICATE OF DEATH.

REGISTERED No. C 792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3508 Fairview Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A Golden.

(Residence in Baltimore: No. 3508 Fairview ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dont Know (Month) (Day), 1856 (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Bankers do

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Rob Golden

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Phila Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daisy Golden

(Address) 3508 Fairview Ave

15- Robert P. Harrison,

Filed....., 191.... Burial Permit Clerk. Registrar.

MAR 22 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21 (Month) (Day), 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from January, 1920, to March 21 1921, that I saw h in alive on March 2, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arteriosclerosis

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilation

(Duration) 2 yrs. mos. ds.

(Signed) E B Harrison M. D.

3/22, 1921 (Address) 412 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL. Mar. 24. 1921

20-UNDERTAKER Geo. J. Smith — ADDRESS 1000 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Pks.

D.52181 (Karl) HEALTH DEPARTMENT—CITY OF BALTIMORE D.52181

CERTIFICATE OF DEATH. 289

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Jackson ST.; 24 WARD)

2-FULL NAME Carol J. Gittings

(a) RESIDENCE. No. 1510 Jackson ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28, 1891

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Drug store

(c) Name of employer Was not employed Zanesville

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER Allen J. Gittings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Zanesville Ohio.

12 MAIDEN NAME OF MOTHER Elizabeth McKay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Cyril Gittings (Address) 1510 Jackson St.

15 Filed MAR 22 1921 Robert T. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1921, to March 20 1921, that I last saw him alive on March 20, 1921, and that death occurred, on the date stated above, at 11.45A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Tuberculous Arthritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) S. H. Sluss M. D.

3/21 1921 (Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cem	3/23. 1921
20 UNDERTAKER Chas. F. Shipley & Sons	ADDRESS 1316 Eutaw St

mation should be carefully supplied. AGE should be stated. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

D.52182 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52182

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 777 Sarah ann ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Barker

(Residence in Baltimore: No. 777 Sarah ann St.; yrs. 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH, ... Dont Know (Month), 1 (Day) ..... (Year)

7-AGE. 55 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Do

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Dont Knows

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Ca ave

15- Filed MAR 22 1921, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Grunow M. D. (Coroner.)

3-22-1921 (Address) 117 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Bur — DATE OF BURIAL, March 23 1921

20-UNDERTAKER Daniel Easton — ADDRESS 916 Ca ave

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52183

CERTIFICATE OF DEATH.

64-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Young

(a) RESIDENCE. NO. ~~Unknown~~ 535 Bloom ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co. Maryland

PARENTS

10 NAME OF FATHER James Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co. Maryland

12 MAIDEN NAME OF MOTHER Alice Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles, Co. Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

MAR 22 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 7, 1920, to March 21, 1921, that I last saw her alive on March 20, 1921, and that death occurred, on the date stated above, at 3 A.M. m.

The CAUSE OF DEATH* was as follows:

Hypertension; cerebral hemorrhage.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) B Heiman, M. D.

3/21/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Mar 23 1921

20 UNDERTAKER: Edmond L. Wright — ADDRESS: 364 Mary

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 24 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Michalana Krasvick (Krawczyk)

(a) RESIDENCE. No. 1152 Cooksie St., St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Krasvick

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jacob Paskowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Wline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records (Address) M.T.H.

15 Filed MAR 22 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1921, to March 19, 1921, that I last saw her alive on March 19, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. H. Fahndrich. M. D.

3-21-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 23 1921
20 UNDERTAKER	ADDRESS
William Faltowski	1018 East

mation should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 52185 HEALTH DEPARTMENT--CITY OF BALTIMORE D. 52185

CERTIFICATE OF DEATH

40

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE (No. 1702 Hanover St. ST. 23 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Susanna Mahn.

(Residence in Baltimore: No. 1702 Hanover St. St.; 50 yrs. --- mos. --- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female.	White.	Widow.

6 DATE OF BIRTH: March 19th. 1844. (Month) (Day), 1 (Year)

7 AGE: 77 yrs. --- mos. 2 ds. — If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Germany.

PARENTS

10 NAME OF FATHER: John Eschenbecker.

11 BIRTHPLACE OF FATHER (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Rosina ----------

13 BIRTHPLACE OF MOTHER (State or country): Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Jos. Fetsch. (daughter)

(Address) 1702 Hanover St.

15 Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MAR 22 1921 191

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 21st. 1921. (Month) (Day), 191 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 14th. 1921 191 ..... to, March 21-21 191 .....,

that I saw her alive on March 20th. 1921 191 .....,

and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach and intestines. (Clinical diagnosis)

(Duration) ..... yrs. 1 mos. ..... ds

Contributory (SECONDARY) Exhaustion.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.

March 21st, 21 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
London Park Cem	March 24th 1921
20 UNDERTAKER	ADDRESS
E Schloman & Son	139 Hanover St

Spec.—8-24-14—M. & T.—2000 Bks.

D.52186 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 William ST.; 24 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth S. Ulrich

(Residence in Baltimore: No. 1011 William St.; 61 yrs., 2 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Jan. 5, 1860 (Month) (Day) (Year)

7-AGE, 61 yrs. 2 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank C. Brandel

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Louisa Brinkman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank C. Ulrich

(Address) 1011 William st

15-

Filed MAR 22 1921, 191.....

Registrar.

Burial Permit Clerk.

R.B.—Every item of information should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21st, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 15th 1921, to Mch. 21st 1921, that I saw her alive on March 16th 1921, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Disease
(Aortic Reg.)
(Duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Failure of Compensation
(Duration) yrs. mos. 1 ds.

(Signed) Howard D. Lewis M. D.
Mch 22 1921 (Address) 38 W. 25th st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, Mch 25 1921

20-UNDERTAKER B. Schloman & Son ADDRESS 1039 Hanover

(Troutman)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52187 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52187

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 N. Gilmor ST.; 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie L. Trautman

(a) RESIDENCE. No. 710 N. Gilmor ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	4	24	

8 OCCUPATION OF DECEASED 069

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) Embroidery,

(c) Name of employer Southern Embroidery Co,

9 BIRTHPLACE (city or town) (State or country) Bedford Co., Pennsylvania.

PARENTS

10 NAME OF FATHER James H. Troutman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Franklin Co. Pa.

12 MAIDEN NAME OF MOTHER Huldah Willison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bedford Co. Pa.

14 Informant Mrs Emily Fetter

(Address) 710 N. Gilmor st

15 Filed ..... 19 Robert F. Harrison, Registrar

MAR 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1921, to March 22, 1921, that I last saw h.. alive on March 21, 1921, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia.

(duration) yrs. mos. 2/ ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? do not know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Maurice L. Shannon, M. D.

3/22 19 / (Address) 3200 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Everett Bedford Co Pa	March 25th 1921
20 UNDERTAKER	ADDRESS 1039
E Schlosman & Son	Hanover Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Bridget A. Feeney)

D.52188 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52188

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1844 Light St.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget A. Feeney

(a) RESIDENCE. No. 1844 Light St., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Feeney

6 DATE OF BIRTH (month, day, and year) Nov 2 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos O'Malley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Daly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary McLaughlin

(Address) 1844 Light

15 Filed MAR 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1921, to Mar 21, 1921, that I last saw h...alive on Mar 20, 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Compobell M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks	3/23 1921
20 UNDERTAKER Margaret J. Flynn	ADDRESS 1433 Light

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52189 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52189

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 Gorsuch Ave ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lana A. Phillips

(a) RESIDENCE. No. 1501 Gorsuch Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sol J. Phillips

6 DATE OF BIRTH (month, day, and year) Feb 4 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo W. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Elizabeth Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Wm Phillips

(Address) 1501 Gorsuch

15 Robert P. Harrison, Registrar

MAR 22 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1921

17

I HEREBY CERTIFY, That I attended deceased from Feby 10, 1921, to Mar 21, 1921, that I last saw h alive on Mar 21, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

MCM

Endocarditis - Age

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) ... yrs. ... mos. 1½ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter N White Jr, M. D.

3/22, 1921 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	March 23 1921
20 UNDERTAKER	ADDRESS
E A Windsor	501 E 20 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal hemorrhage

D52190 HEALTH DEPARTMENT--CITY OF BALTIMORE D52190

CERTIFICATE OF DEATH

REGISTERED NO. C 92

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 419 West Hamburg ST. 21 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thelma L. Gross

(Residence in Baltimore: No. 419 W Hamburg St St.; yrs. 3 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
female	colored	single

6 DATE OF BIRTH Dec 11, 1920 (Month) (Day) (Year)

7 AGE yrs. 3 mos. 10 ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work not any yet
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto md

PARENTS

10 NAME OF FATHER Robert Gross

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Borans

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louise Gross

(Address) 419 W Hamburg St

15 Filed MAR 23 1921, 191 ROBERT A KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 21, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 21, 1921, to Mar 21 1921, that I saw her alive on Mar 21, 1921, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ? ds

Contributory (SECONDARY) Convulsions for twenty

(Duration) yrs. mos. 1 ds,

(Signed) J. F. Dunbar M. D.

3/22/, 1921. (Address) 301 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Auburn ✝ | DATE OF BURIAL March 23, 1921

20 UNDERTAKER H. W. Brown & Son | ADDRESS 108 N. Monroe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52191

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 5-2191

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 4 Southern Ave St.; Belair Rd (WARD) 27)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanca Bolas Balas

(Residence in Baltimore: No. 4 Southern Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, Dec 8, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md Balto

PARENTS.

10-NAME OF FATHER George Balas

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Anastopulo

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Geo. Balas.....

(Address).....4 Southern ave.....

15- MAR 23 1921 ROBERT A KRAUTER
Filed....., 191... Registrar.

Burial Permit Issued

N. B.—Every item of information should be carefully given. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1921, to March 21 1921, that I saw h.e alive on March 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Dyspepsia

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

March 22, 1921 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	March 23, 1921
20-UNDERTAKER	**ADDRESS**
John Gubelmanos	420 S Paca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52192

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 619 N. Spring ST.; 7 WARD)

2-FULL NAME Emma F. Johnson

(a) RESIDENCE. No 619 N. Spring ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles J. Johnson

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Joseph Pierce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Charlotte Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Charles J. Johnson
(Address) 619 N Spring St

15 Filed MAR 23 1921 ROBERT J. CRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1920, to March 20, 1921, that I last saw h[illegible] alive on March 20, 1921, and that death occurred, on the date stated above, at 10:45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Menopause

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dr. B. Robinson, M. D.

1921 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	March 23 1921
20 UNDERTAKER	ADDRESS
Mrs J. G. Locks	1302 Jefferson

N. B.—[illegible] should be carefully supplied. AGE should be stated EXACTLY. FULL information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52193 (143 293)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52193

CERTIFICATE OF DEATH.

REGISTERED NO. 579

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp (ST.) 5 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wilkins

(a) RESIDENCE. No. 418 Orleans St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cobbler - Shoe

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Edw. Wilkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record
(Address) J. H. H.

15 Filed MAR 23 1921 ROBERT A. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 - 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 31 - 1920, to March 21 - 1921, that I last saw h.. alive on March 21 - 1921, and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

Cardio-renal-vascular disease.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood pressure findings

(Signed) Edward C. Davidson M. D.

3-23, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Warrenton Va.	March 23 1921
20 UNDERTAKER	ADDRESS
Thos J. G. Locke	1302 Jefferson

NOTE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D52194 HEALTH DEPARTMENT—CITY OF BALTIMORE D52194

CERTIFICATE OF DEATH. 19-002

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 108 Thursby Court ST.; 9 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrol Scott

(Residence in Baltimore: No. 108 Thursby Court St.; yrs., 6 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Mal

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sing

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 1 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Driver
(b) General nature of industry, business, or establishment in which employed (or employer)..... Driver

9-BIRTHPLACE, (State or Country), Bir in Balt Co much Jonson town Md

PARENTS.

10-NAME OF FATHER, Robert Scott

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Georgie Diggs

13-BIRTHPLACE OF MOTHER (State or Country), Balt Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Diggs

(Address) 108 Thirsby Court

15- Filed MAR 23 1921 ROBERT I KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon; and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chicken Pox

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

5-21-21 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Jonson Md

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem — DATE OF BURIAL, March 23 1921

20-UNDERTAKER Chas R A Elliott — ADDRESS 1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

Davey.

D52195 HEALTH DEPARTMENT—CITY OF BALTIMORE D52195

CERTIFICATE OF DEATH.

REGISTERED NO. 479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Eden al ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Davey

(a) RESIDENCE. No. 718 Eden al ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? 38 yrs. 1 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38.	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Oxford Md

PARENTS

10 NAME OF FATHER: Thomas Davey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Louisa Anthony

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talbot Co

14 Informant: Louisa Anthony (Address) Tal Bottle Shop N J

15 Filed MAR 23 1921 ROBERT A LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 21, 1921, that I last saw her alive on March 21, 1921, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Been suffing with pain in brust shortness of breath, pain shoulders for indefinate period time indefinate

Mitral Stenosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

Lardinitis (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) L B Evans, M. D.

3/24/1921 (Address) Grand & Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: March 24 1921

20 UNDERTAKER: Samuel Hendley

ADDRESS 778 Biddle

N. B.—WRITE plainly with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052196

HEALTH DEPARTMENT—CITY OF BALTIMORE

052196

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. ..... WARD)

2-FULL NAME Lulu Johnson

(a) RESIDENCE. NO. 614 Pitcher st. ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown (mos. 11) ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Purbush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) V. T. H.

15 Filed MAR 23 1921 ROBERT I. BRAUER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 17, 1921, to March 21, 1921, that I last saw her alive on March 20, 1921, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? .....

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) H. S. Fahnbush, M. D.

3-21-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gordonsville Va

DATE OF BURIAL Mar 23 1921

20 UNDERTAKER Emmett Hensley

ADDRESS V 78

Information should be carefully supplied. AGE should be stated EXACTLY. Particulars of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052197

HEALTH DEPARTMENT—CITY OF BALTIMORE

052197

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 S. Bond St. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Klavansky

(a) RESIDENCE. No. 103 S. Bond St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Klavansky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Levkon
(Address) 103 S. Bond St

15 MAR 23 1921 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to Mch 23, 1921, that I last saw h[illegible] alive on Mch 22, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hypertension, Urine

(Signed) Jacob Levkon, M. D.

Mch 23, 1921 (Address) 223 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale Cemet.	Mar 23 1921
20 UNDERTAKER Max Levinson	ADDRESS 1127 E Balto St

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

052198

HEALTH DEPARTMENT—CITY OF BALTIMORE

052198

CERTIFICATE OF DEATH.

43

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2017 E Chase ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Staub

(Residence in Baltimore: No. 2017 E Chase St.; 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 6, 1875
(Month) (Day) (Year)

7-AGE, 46 yrs. 1 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, John H Kirkton

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret Doak

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clement D Staub

(Address) 2017 E Chase

15-

FILED MAR 23 1921 191.... ROBERT J KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 16 191.., to Mar 21 1921, that I saw h-e alive on Mar 20 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma of Breast (Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (Duration) yrs. mos. ds.

(Signed) Walter W White M. D.

Mar 22 1921. (Address) 2806 St. Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lauverta | DATE OF BURIAL, Mar 24 1921.

20-UNDERTAKER Jos Cobb & Johnson | ADDRESS 1742 Gay

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH must be properly classified. See instructions in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N. Wolfe ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory Leasure

(a) RESIDENCE. NO. 811 N. Wolfe ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. 6 mos. 19 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment In which employed (or employer) U S Army

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Emory Leasure

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash D. C.

12 MAIDEN NAME OF MOTHER Ella Fortine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Annie Leasure

(Address) 811 N Wolfe St

15 Filed MAR 23 1921 ROBERT E. GRAETZ Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21st 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1920, to Mar 21, 1921, that I last saw him alive on Mar. 21, 1921, and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Mustard gas infection — Pulmonary Tuberculosis (duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Over seas.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. J. Roberts, M. D.

, 19 (Address) 451 E 22nd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Mar 25 1921
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son,	811 N Wolfe

Funeral Directors & Embalmers.

NATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52200

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52200

CERTIFICATE OF DEATH.

55-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. McLemore

(a) RESIDENCE. No. 316 Sharp St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sweeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed MAR 23 1921 LOWER & KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 21, 1921

that I last saw him alive on March 21, 1921

and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Lethargic encephalitis.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia. (duration) yrs. mos. 3. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) Patterman. M. D.

3/21/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mch 24 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Lombard St

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

852201

HEALTH DEPARTMENT—CITY OF BALTIMORE

852201

CERTIFICATE OF DEATH.

REGISTERED NO. 34

1-PLACE OF DEATH US. Public Health Hosp. #56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Fort McHenry Baltimore Md. ST.: 2nd WARD)

2-FULL NAME William H. Foots

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST. Fort McHenry Baltimore Md. WARD
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Willain Foots

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rueckert Registrar

(Address) US. Public Health Hosp. #56

15 Filed MAR 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15 1921, 19..., to March 20, 1921, that I last saw him alive on March 20 1921, and that death occurred, on the date stated above, at 11'30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Bone.(lumbar vertebra)

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam. Clinic report

(Signed) Thomas B. Payne M. D. Senior Surgeon (R

, 19 (Address) US. PHS. Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mch 24 1921
20 UNDERTAKER John W. Bradnin	ADDRESS 142 Ostend St

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-13—H. F. Co.—1000 Blks.

D46819

D52202

HEALTH DEPARTMENT—CITY OF BALTIMORE

37 D52202

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Harry Williams

(a) RESIDENCE. NO. 105 N. Carlton St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Williams

6 DATE OF BIRTH (month, day, and year) June 5 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Record

15 Filed MAR 23 1921 ROBERT J. KRAMER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 12 1921, to March 21 1921, that I last saw him alive on March 21 1921, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia,
Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Aneurysm of aorta

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Hospital examination

(Signed) Henry M. Thomas Jr. M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 23 1921
20 UNDERTAKER	ADDRESS 1142 N
Brown & Friedland	Schroeder

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business. that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probable Lues

Spec.—6-9-19—H. P. Co.—1000 Bks.

052203

HEALTH DEPARTMENT—CITY OF BALTIMORE

052203

CERTIFICATE OF DEATH.

79 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Bruckert Ave. ST.: Hamilton WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melchoir Weller

(a) RESIDENCE. NO. 7 Bruckert Ave. ST., WARD. 27.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Weller.

6 DATE OF BIRTH (month, day, and year) April 12, 1844.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	11	9.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Shoer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant Katharine Weller.
(Address) 7 Bruckert Ave.

15 Filed ....., 19.... ROBERT P. BRADFORD Registrar

MAR 23 1921 Burial Permit 01008

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1921

17 I HEREBY CERTIFY, That I attended deceased from March 13 —, 1921, to March 22, 1921, that I last saw h— alive on March 20 —, 1921, and that death occurred, on the date stated above, at 9.20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular - Heart Dis. - (Arterio - Sclerosis)

— (duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Coma - Uremia -

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Dr. E. Brunner, M. D.

, 19 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cemetery	March 25 1921
20 UNDERTAKER	ADDRESS
C. Heemann.	32 S. Broadway.

Information should be carefully supplied. AGE should be stated EXACTLY. Fractions of days should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52204

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 914 N. 38th. ST.: (WARD) 13

2-FULL NAME Sarah A. Arthur

(a) RESIDENCE. NO. 914 N. 38th. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Arthur Sr.

6 DATE OF BIRTH (month, day, and year) Jan. 30-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Rachael Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Wm. H. Arthur Sr.
(Address) 914 N. 38th. St.

15 Filed MAR 23 1921 Wm. H. Arthur
Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1921

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1921, to March 22, 1921, that I last saw her alive on March 22, 1921, and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary edema
Cerebral hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis, Endocarditis
(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. H. Machen, M. D.

. 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	March 25 1921

20 UNDERTAKER Horace Burgee & Son ADDRESS 363 Fall Rd.

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Miller

D52205

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52205

CERTIFICATE OF DEATH.

123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 13 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George G Fuller

(Residence in Baltimore: No. 1311 Mosling Ave St.; 20 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. Accurate AGE should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 23 (Day) 1873 (Year)

7-AGE, 47 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinist Helper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Carroll Co. Md

PARENTS.

10-NAME OF FATHER, Wm. H. Miller

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co. Md

12-MAIDEN NAME OF MOTHER Matilda Garvick

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ella May Miller

(Address) 1311 Mosling Ave

15-

Filed MAR 23 1921, 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22 (Month) (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from March 3 1921, to March 22 1921, that I saw b[illegible]alive on March 22 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tuberculosis stone, sinus
Post operative adhesions
Cirrhosis of peritoneum
(Duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. 2 ds.

(Signed) C. Coles S. Guy M. D.
3-22-, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 19 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 1311 Mosling Ave

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Hampden — DATE OF BURIAL, March 25 1921

20-UNDERTAKER Horace Burgee & Son — ADDRESS 3631 Falls Rd.

Spec.—6-9-19—H. P. Co.—1000 Bks.

952206

HEALTH DEPARTMENT—CITY OF BALTIMORE

952206

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sagamore Aprt. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Adler.

(a) RESIDENCE. NO. Lakeview Ave.; ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 9th. 1874.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Louis Adler,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER Annie Rosenfeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. md

14 Informant Mrs. Koshland, (Address) Sagamore Aprt.

15 Filed MAR 23 1921 ROBERT I. KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1919, to March 22, 1921, that I last saw her alive on March 22, 1921, and that death occurred, on the date stated above, at 11 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia - general (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 1/2 yr ago

Was there an autopsy? no

What test confirmed diagnosis? see other side

(Signed) J. Frederick Lentz, M. D.

3/22, 1921 (Address) 2040 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew, DATE OF BURIAL Mch. 23th, 21

20 UNDERTAKER Harris Sondheim ADDRESS 1818 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH LINK OR INDELIBLE PENCIL. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

952207

HEALTH DEPARTMENT—CITY OF BALTIMORE

952207

CERTIFICATE OF DEATH.

18-011

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Estelle Droste

(a) RESIDENCE. NO. 1921 Park Ave. ST., 13 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 1 mos. ? ds. How long in U. S., if of foreign birth? 53 yrs. 1 mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (None)

6 DATE OF BIRTH (month, day, and year) Feb-?-1868.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	1	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) Railways.

(c) Name of employer United Railways Comp'y

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Droste

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C. Droste

13 BIRTHPLACE OF MOTHER (city or town) Kent Co.
(State or country) Maryland.

14 Informant Mr. Amos G. Start (uncle)
(Address) #3209 N. Charles St.

15 Filed MAR 23 1921 ROBERT I. KRAUTH Registrar

Burial Permit Oiled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1921, to March 23, 1921, that I last saw her alive on March 22, 1921, and that death occurred, on the date stated above, at 1:50 a. m.

The CAUSE OF DEATH* was as follows:

Erysipelas.
Chronic myocarditis.

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B. MacGowan, M. D.

3/23/21 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Mar-25-21

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION

Spec.—8-24-14—M. & T.—2000 Bks.

D-52208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-52208

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 551 Mosher ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Marks

(Residence in Baltimore: No. 551 Mosher St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	C

6-DATE OF BIRTH, March (Month) 5 (Day), 1921 (Year)

7-AGE, Two yrs. Two mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....(.....)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Mercy Hospital

PARENTS.

10-NAME OF FATHER, Jacob Marks

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Jessie Israelson

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L. Mullen

(Address) 1020 N. Calvert St.

15-

Filed MAR 23 1921 ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1921, to March 22 1921, that I saw h.. alive on March 22 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Prematurity

7 months foetus

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) William L. Mullen M. D.

March 23 1921. (Address) 1020 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Washington Cem

DATE OF BURIAL, Mar 23, 1921

20-UNDERTAKER M. Levinson

ADDRESS 1127 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052209

HEALTH DEPARTMENT—CITY OF BALTIMORE

052209

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 732 Columbia Ave ST.: 21 WARD)

2-FULL NAME. Lucy Courtree

(a) RESIDENCE. No. 732 Columbia ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: of Fred Courtree

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Wm Poyggson

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Eliz Samuels

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Lucy Evans
(Address) 732 Columbia

15 Filed MAR 23 1921 SOREY B. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Mar 19, 1921, that I last saw h alive on, 19, and that death occurred, on the date stated above, at 6 50 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stanley Stoag, M. D.

3/23, 192 (Address) 29 Herkimer

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 22 1921
20 UNDERTAKER	ADDRESS
H. Richardson	Baltimore

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D52210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52210

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Genl. Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean Frances Yewell.

(a) RESIDENCE. No. Md Genl Hosp. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Sngle

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 6 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Francis E Yewell

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Jean Johnson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Francis E Yewell.
(Address) 2201 Aisquith St

15 Filed MAR 23 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-6-21, 19 , to 3-23, 19 21, that I last saw her alive on 3-23-21, 19 , and that death occurred, on the date stated above, at 5-53 a m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 3 hrs.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) R. H. Richardson, M. D.

, 19 (Address) Md. Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	3/24/21
20 UNDERTAKER	ADDRESS
W J Sahm & Son	Pulaski

N.B.—WRITE PLAINLY, with pen and ink. PHYSICIANS should be careful that the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

052211 HEALTH DEPARTMENT—CITY OF BALTIMORE 052211

CERTIFICATE OF DEATH.

(PLACE OF DEATH

CITY OF BALTIMORE (No. 1721 Division ST.: 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roseanna Wilks

(Residence in Baltimore: No. 1721 Division St. St.; 3 yrs., mos. ds.)

WRITE PLAINLY, with pen and ink. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, ... November (Month) ..... (Day) ....., 1865 (Year)

7-AGE, ... 56 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John H. Eagleu

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Nelson

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Coates

(Address) 1721 Division St.

15-

Filed MAR 23 1921 191..... ROBT. J. KRAMER Registrar.

Burial Permit Sent

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March 21 (Month) (Day) ....., 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

March 22 1921 (Address) 2512 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, La Plata Md

DATE OF BURIAL, March 24, 1921

20-UNDERTAKER Joseph A Farrell

ADDRESS 2314 Division St

Spec.—6-9-19—H. P. Co.—1000 Bks.

946 805

HEALTH DEPARTMENT—CITY OF BALTIMORE

952212

952212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 8

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred B. Jefferson.

(a) RESIDENCE. NO. 815 McDonough St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29. 920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. fld

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Viola Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. H. Hospital Records.
(Address)

15 Filed MAR 23 1921 ROBERT J. KRAUTH Registrar
Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied. PHYSICIANS should state EXACTLY. mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1921

17

I HEREBY CERTIFY, That I attended deceased from March 11— 1921, to March 21 1921,

that I last saw h.... alive on March 21 1921,

and that death occurred, on the date stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Rickets

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No yes.

What test confirmed diagnosis? None (X-ray)

(Signed) L. W. Sharp M. D.

3-22, 1921 (Address) P H H Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	MAR 22 1921 19
20 UNDERTAKER	ADDRESS

Commissioner Health.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 46947 / D 52213 — 151 D 52213

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Eckert

(a) RESIDENCE. NO. 221 N Wolfe St. Baltimore ST., Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Record
(Address)

15 MAR 23 1921 ROBERT A KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 20, 1921, that I last saw him alive on March 20, 1921, and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W P Sarran, M. D.

3-26 1921 (Address) 4HH Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	MAR 22 1921 19
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

106

Spec.—8-24-14—M. & T.—2000 Bks.

D52214

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52214

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 N. Wolfe St.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Teresa Laflame

(Residence in Baltimore: No. 625 N. Wolfe St. St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	white	

6-DATE OF BIRTH, March 19th, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George Laflame

11-BIRTHPLACE OF FATHER (State or Country), Mass.

12-MAIDEN NAME OF MOTHER Nettie Anderson

13-BIRTHPLACE OF MOTHER (State or Country), West Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Laflame

(Address) 625 N. Wolf St.

15- MAR 23 1921 ROBERT J. KRAUTHOFF Registrar. Filed....., 191. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 22 1921, to March 23 1921, that I saw h er alive on " " 1921, and that death occurred, on the date stated above, at 8:30A m.

The CAUSE OF DEATH* was as follows:

Birth Palsy (Meningeal Hemorrhage)

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank J Ayd M. D.

Mar 23, 1921 (Address) 2005 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Patrick's Cem

DATE OF BURIAL, 3 23, 1921.

20-UNDERTAKER Wm. D. Schaffer ADDRESS 1816 E. Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bimia

052215 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 052215

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3127 Elliott St ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Benia

(a) RESIDENCE. No. 3127 Elliott ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. — mos. — ds. How long in U. S., if of foreign birth? Bulk yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. PHYSICIAN'S should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1917 - Aug 28

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md. U.S.A.

PARENTS

10 NAME OF FATHER: John Benia

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland Russia Bohemia

12 MAIDEN NAME OF MOTHER: Mary Iwan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland Bohemia

14 Informant: John Benia

(Address): 3127 Elliott St

15 MAR 23 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 22 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-16-, 1921, to 3-20-, 1921, that I last saw h[im] alive on 3-19-, 1921, and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

convulsions

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Tumor

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Wisman M. D.

(Address) 308 Biway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Mar 24 1921
20 UNDERTAKER	ADDRESS
Stephen L. Fralkowski	100 Kenyon

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52216

CERTIFICATE OF DEATH.

REGISTERED NO. 9-D. 52216

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelina Barone

(a) RESIDENCE. NO. 1417 E. Clement ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 29-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Barone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Emma Romano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) John Barone 1417 Clement St.

15 Filed MAR 23 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to March 23, 1921, that I last saw h... alive on March 23, 1921, and that death occurred, on the date stated above, at 7:00 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal.

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Positive cultures.

(Signed) B. MacGowan M. D.

, 19 (Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Cem. DATE OF BURIAL 3/23. 1921

20 UNDERTAKER Margaret J. Flynn ADDRESS 1423 Light St.

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

D.52217 (Smith) HEALTH DEPARTMENT—CITY OF BALTIMORE D.52217

CERTIFICATE OF DEATH.

REGISTERED No. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mersity Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josie Smith

(Residence in Baltimore: No. 629 Smith St

St.; yrs,, mos. ds.)

PHYSICIANS.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	Colored	Single

6-DATE OF BIRTH, March 10, 1919
(Month) (Day) (Year)

7-AGE, 2 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John Smith

11-BIRTHPLACE OF FATHER (State or Country), S Carolina

12-MAIDEN NAME OF MOTHER Lillie Bamister

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Delia Brooks

(Address) 629 Smith St

15- Robert P. Harrison,
Filed ....., 191.... Registrar.

MAR 23 1921 Burial Permit Clark.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

From burns over body

(Duration) yrs. 3 hours mos. ds.

CONTRIBUTORY (Secondary) Flames with Malaytes a few hours

(Duration) yrs. mos. ds.

(Signed) W. K. Grossmah M. D.
(Coroner.)

3.22, 1921. (Address) 117 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	3.24.23, 1921.
20-UNDERTAKER	**ADDRESS**
Edw. Ringgold	1463 N. Fremont

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52218 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52218

92-064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Coyne.

(a) RESIDENCE. No. St. Agnes Hosp ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If nonresident give city or town and State)

How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	45 yrs	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm hand do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " Unknown

12 MAIDEN NAME OF MOTHER " Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " Unknown

14 Informant Peter Coyne
(Address) St Agnes Hospital

15 Filed ..... 19 .....
Robert P. Harrison, Registrar
Burial Permit Clerk.

MAR 23 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-20, 1921, to 3-23, 1921, that I last saw h[illegible] alive on 3-23, 1921, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Wm. H. Craig, M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem. Co	3/24 1921
20 UNDERTAKER	ADDRESS
C. D. Evans & Son	118 N. Mt Royal Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic + Lobar

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52219

80

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 E. Preston ST.: 10 WARD)

2-FULL NAME Joseph R. Degenhardt

(a) RESIDENCE NO. 917 E. Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Marr[illegible]

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary M. Degenhardt

6 DATE OF BIRTH (month, day, and year) Dec. 4 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Building Inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Mun.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER August Degenhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Grimmard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary M. Degenhardt.
(Address) 917 E. Preston St.

15 Filed ....., 19 .....
Robert P. Harrison, Registrar

MAR 23 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5 1921 to March 20 1921, 19..... to 19.....

that I last saw him alive on March 20 1921, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Chronic (duration) 1 yrs. mos. ds.

CONTRIBUTORY Myocardial Dilatation
(Secondary) (duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death? Washington D. C.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed J. Phillips Bond M. D.

March 23 1921 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: March 25 1921

20 UNDERTAKER: Henry Hoerth Son — ADDRESS: 1301 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52220 HEALTH DEPARTMENT—CITY OF BALTIMORE D52220

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 Mangold St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Fitzpatrick

(a) RESIDENCE. No. 933 W. Lombard St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Fitzpatrick

6 DATE OF BIRTH (month, day, and year) July 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Mrs. Mary Dillon

(Address) 933 W. Lombard St.

Dec'd. MAR 23 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21" 19 21

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to March [illegible] 1921, that I last saw h[illegible] alive on March 1[illegible], 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. [illegible] mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. [illegible] mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) [illegible], M. D.

3/22, 1921 (Address) 729 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	March 24 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook.	1003 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.52221 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52221

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mount Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Mobley

(a) RESIDENCE. NO. Winnsboro S. C. - ST., 28 WARD. (Winnsboro S.C.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 83 yrs — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs Mobley

6 DATE OF BIRTH (month, day, and year) Sept 27-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82 ##	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician - 05

(b) General nature of industry, business, or establishment in which employed (or employer) Medicine -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winnsboro S. C

PARENTS

10 NAME OF FATHER Simeon Mobley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Winnsboro S.C -

12 MAIDEN NAME OF MOTHER Helen Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fairfield Co S. C.

14 Informant Record of Mt Hope Retreat (Address) Mt Hope Baltimore -

15 Filed MAR 23 1921, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1890 .19.. to Mch 23rd .1921. that I last saw him alive on Mch 22nd .1921. and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Post senile sclerosis)

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Terminal Dementia - Post Clon. Mania - abt (duration) 44 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Winnsboro S. C.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Mch 23rd 1921 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winnsboro S.C.	Mar/23/ 1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52222

4 52222

80

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 113 N Monument St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME H Crawford Black

(a) RESIDENCE. No. 113 N Monument St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Financier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Allegany Mountains

PARENTS

10 NAME OF FATHER H. D Black

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumberland

12 MAIDEN NAME OF MOTHER Mary Ann Baldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs. Wm Lear Black

(Address) 113 N Monument St

15 Filed ..... 19 ..... Registrar

MAR 24 1921

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3rd, 1919, to March 22, 1921, that I last saw h.. alive on March 22, 1921, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Arteriosclerosis, Coronary clot.)

(duration) 15 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Thrombosis, Coronary artery (duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Linus P. Hunsberger, M. D.

Mar 23, 1921 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 24 1921
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Co	Richard & Lyon Ellis

MAR 24 1921

N. B.—WRITE PLAINLY, WITH CARBON PENCIL. PHYSICIANS should state be stated EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52223

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 archer ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lola Scroggins

(a) RESIDENCE. No. 612 archer ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 21, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) maryland

PARENTS

10 NAME OF FATHER Wilson Chandler

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) maryland.

12 MAIDEN NAME OF MOTHER Mary Scroggins

13 BIRTHPLACE OF MOTHER (city or town) U. S. A.
(State or country) maryland

14 Informant Mary Scroggins
(Address) 612 Archer St

15 Filed ....., 19.... [illegible] Registrar
MAR 24 1921 Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52224

CERTIFICATE OF DEATH.

REGISTERED NO. 1492

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Nellie Ball

(a) RESIDENCE. NO. 1415 Mt. Royal Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Rev. C. Sturges Ball

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) London England

PARENTS

10 NAME OF FATHER Samuel Glendenning

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elena Jefferson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Rev. C. Sturges Ball

(Address) 1415 Mt. Royal Ave

15 MAR 24 1921 ROBERT I. KRAUTZ Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/28 1921, to 3/22 1921, that I last saw her alive on 3/22 1921, and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. O. Riley, M. D.

3/23 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 25 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. Nath Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D52225

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 E. Eager St.: 10 WARD)

2-FULL NAME Mary Warnbold

(a) RESIDENCE. NO. 612 E. Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

* Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Albert. Warnbold

6 DATE OF BIRTH (month, day, and year): March 1850

7 AGE: Years 71 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Dont. Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Albert Warnbold
(Address): 612 E. Eager St

15 Filed . 19 Registrar

MAR 24 1921 ROBERT A KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 22 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to Mar 22, 1921, that I last saw h.. alive on March 19, 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) About 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

3/27/1921 (Address) 700 C Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel

DATE OF BURIAL: March 24 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

952226

HEALTH DEPARTMENT—CITY OF BALTIMORE

952226

CERTIFICATE OF DEATH.

8

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 9 WARD)

2-FULL NAME Gilbert Franck

(a) RESIDENCE. No. 1702 Abbottston St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1920

7 AGE: Years — Months 8 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Theodore S. Franck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie F. Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address) J. H. H.

15 Filed MAR 24 1921 ROBERT J. KRAUSE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21 1921 to March 23 1921, that I last saw h— alive on March 23 1921, and that death occurred, on the date stated above, at 12 39 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W C Davison, M. D.

19 (Address) JHH Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	3/25 19—
20 UNDERTAKER	ADDRESS
Wilbur Cook	502 E Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052227

HEALTH DEPARTMENT—CITY OF BALTIMORE

052227

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Merritt.

(a) RESIDENCE. No. 2147 Hartford Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Merritt.

6 DATE OF BIRTH (month, day, and year) October 1- 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~28~~	31	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Alexander Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary J. England

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Alfred E. Conrath 1404 Leadenhall Ave

15 F... MAR 24 1921 ...ERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23 1921

17

I HEREBY CERTIFY, That I attended deceased from 3/17 1921, to 3/23 1921,

that I last saw h[er] alive on 3/23 1921,

and that death occurred, on the date stated above, at 4.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema (R)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/15/21

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Autopsy.

(Signed) Wm Stent, M. D.

3/23, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 26 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52228

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 E. Biddle ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard C. Reid

(a) RESIDENCE. NO. 611 E. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Bessie R Reid

6 DATE OF BIRTH (month, day, and year) Oct 6 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard H. Reid

11 BIRTHPLACE OF FATHER (city or town) Norfolk (State or country) Virginia

12 MAIDEN NAME OF MOTHER Jane H. Harvey

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country) Maryland

14 Informant Margaret A Harvey (Address) 611 E. Biddle St

15 Filed MAR 24 1921 ROBERT P. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1921

17 I HEREBY CERTIFY, That I attended deceased from January, 1921, to March 22, 1921, that I last saw h~~im~~ alive on March 21, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pleurisy

Duration (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tuberculosis Found Bacteria

(Signed) Joseph L. Valentine M. D.

Mar 25 1921 (Address) 2 W. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Mar 25 1921

20 UNDERTAKER John B Spence ADDRESS 1326 N Caroline St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA CAUSE OF DEATH in plain terms, so that it may be properly classified. be properly classified. TION is very important. See instructions on back of certificates. of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52229

D52229

CERTIFICATE OF DEATH.

REGISTERED NO. C 79 D52229

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2700 Allan Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah R. Dell

(Residence in Baltimore: No. 2700 Allan Ave St.; 68 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May 27, 1853 (Month) (Day) (Year)

7-AGE, 68 yrs. 10 mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Andrew Jones

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER, Mary A. Brown

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Webster Jones

(Address) Eutaw Place & Park

15- Filed MAR 24 1921, 191. ROBERT F KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 21, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 4 1921, to March 21 1921, that I saw her alive on March 21 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Sclerosis of
Chronic Myocarditis
Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (Duration) yrs. mos. 1 ds.

(Signed) M. D.

3/24/, 1924. (Address) 3429 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden | DATE OF BURIAL, Mar 24, 1921

20-UNDERTAKER G. F. Marshall | ADDRESS 358 Fallsway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D5-2230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D5-2230

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 813 Beaumont Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Patrick Linsmann

(Residence in Baltimore: No. 813 Beaumont Ave St.; 31 yrs., 8 mos. 2 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, July (Month) 21 (Day) 1889 (Year)

7-AGE, 31 yrs. 8 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Jackson City Miss

PARENTS.

10-NAME OF FATHER, Jefferson Davis Linsmann

11-BIRTHPLACE OF FATHER (State or Country) Corinth mill Miss

12-MAIDEN NAME OF MOTHER Mary Elizabeth Funcity

13-BIRTHPLACE OF MOTHER (State or Country), Corinth mill Miss

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. Linsmann

(Address) 813 Beaumont Ave

15- MAR 24 1921 Filed....., 191.... ROBERT J. BRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 19 1921, to March 23 1921, that I saw him alive on March 22 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Coma Diabeticum

(Duration).....yrs.....mos...1....ds.

CONTRIBUTORY (Secondary) Diabetes (Duration).....yrs.....1 mos.....ds.

(Signed).....A. H. Mayer.....M. D.

3-24, 1921. (Address) 2438 Guilford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, WC Brooks. DATE OF BURIAL, March 27, 1921

20-UNDERTAKER Texas Md. ADDRESS Texas Md

Spec.—8-24-14—M. & T.—2000 Blks.

D52231 HEALTH DEPARTMENT—CITY OF BALTIMORE D52231

92-10

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 E Biddle ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine E Schmidt.

(Residence in Baltimore: No. 1423 E Biddle St.; 44 yrs., 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb 14, 1877
(Month) (Day) (Year)

7-AGE, 44 yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo Roberer

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Louisa List

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm C Schmidt

(Address) 1423 E Biddle St

15- MAR 24 1921 Filed....., 191.... ROBERT J KRAUTLE Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3. 22, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 11 1921, to Mch 22 1921, that I saw h- alive on Mch 21 1921, and that death occurred, on the date stated above, at 1 1. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Type I.V.

(Duration).....yrs.....mos. 11....ds.

CONTRIBUTORY (Secondary) La Grippe

(Duration).....yrs.....mos. 11....ds.

(Signed) H. C. Pole M. D.

3 23, 1921. (Address) 203 Mathias Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Mar 24, 1921.

20-UNDERTAKER W M Roulson — ADDRESS 2235 N Monroe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D52232 HEALTH DEPARTMENT—CITY OF BALTIMORE D52232

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 725 S. Ellwood Ave. ST.: 1 WARD) 79 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Webel

(Residence in Baltimore: No. 725 S. Ellwood Ave St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, March (Month) 22 (Day), 1871 (Year)

7-AGE, 50 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Charles Hotz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Garies

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christian Webel

(Address) 725 S. Ellwood Ave.

15- MAR 24 1921 ROBERT I KRAUTER
Filed ..... 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 22 (Day) 1921 (Year), 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
(Coroner.)

3/22/21, 191.. (Address) 1600 N Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oaklawn	March 25 19 21
20-UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52233 HEALTH DEPARTMENT—CITY OF BALTIMORE D52233

CERTIFICATE OF DEATH. 109

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 727 N. Chester ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Lloyd

(a) RESIDENCE. NO. 727 N. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tristy Lloyd Sr.

6 DATE OF BIRTH (month, day, and year) Mar. 4 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John P. Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannora —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Tristy Lloyd Sr. (Address) 727 N. Chester St.

15 Filed MAR 24 1921 ROBERT I. KRAETER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1921, to March 21, 1921, that I last saw h.e alive on March 21 1921, and that death occurred, on the date stated above, at 12 50 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Wm A Gage, M. D.

3/23 1921 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem — DATE OF BURIAL: Mar 24 1921

20 UNDERTAKER: Philip Stewig — ADDRESS: 2016 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52234

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52234

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3211 Esther Pl. St.; 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Ritter

(a) RESIDENCE. No. 3211 Esther Pl. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan-6-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Charles J. Ritter

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Foertsch

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Barbara Ritter
(Address) 3211 Esther Pl

15 Filed MAR 24 1921, 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1921

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to March 22, 1921,

that I last saw h. alive on March 22, 1921,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Intestinal - Toxemia

(duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John F. Owens, M. D.

March 23, 19 (Address) Fairmont & McPherson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	3-24 1921
20 UNDERTAKER J. A. Moran	ADDRESS 900 E Baltimore

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro

D52235 HEALTH DEPARTMENT—CITY OF BALTIMORE D52235

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 9. E. Fayette St. 12 WARD) REGISTERED No. C 64

2-FULL NAME Albert W. Lutts

(Residence in Baltimore: No. 448 E. 22nd st.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, March (Month) 3 (Day), 1851 (Year)

7-AGE,	If LESS than 1 day,
70 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Life Insurance agent
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John Lutts

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Mary Mansfield

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ema Lutts

(Address) 448 E. 22 St.

15- ROBERT J. KRAUTER

Filed MAR 24 1921 191 Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy~~ or inquiry.) thereon and from the evidence obtained by said (Inquest, au-topsy or inquiry.) did that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) a few hours

CONTRIBUTORY (Secondary) Don't Know Any

(Duration) yrs. mos. ds.

(Signed) W. F. Gruesch M. D. (Coroner.)

3-24 1921 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, March 19 25

20-UNDERTAKER E. A. Winfield Jr.

ADDRESS 501 E. 22nd St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D52236

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D52236

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 S Wolfe ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Grein

(Residence in Baltimore: No. 616 S Wolfe St.; ....yrs., ...mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	White	Infant

6-DATE OF BIRTH, March (Month) 7 (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): Child

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Michael Grein

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Gray

13-BIRTHPLACE OF MOTHER (State or Country), Rode Island

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Grein

(Address) 616 S. Wolfe

15- MAR 24 1921 ROBERT F. BRAUTIGAM

Filed ....., 191.... Special Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 23 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1921, to March 23 1921, that I saw h.. alive on March 23 1921, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ....yrs. 6 mos. 10 ds.

CONTRIBUTORY (Secondary)

.....C. (Duration) ....yrs. ....mos. ....ds.

(Signed) Irma A. Lamprecht M. D.

3/24, 1921 (Address) 2431 Eastern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus	March 24, 1921
20-UNDERTAKER Wendell Kerfoot Son	ADDRESS 373 Aisquith

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52237

CERTIFICATE OF DEATH.

D52237

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2534 Foster av ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Gorzewicz

(Residence in Baltimore: No. 2534 Foster av St.; 36 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Married

6-DATE OF BIRTH, September 4, 1850
(Month) (Day) (Year)

7-AGE, 70 yrs. 6 mos. 18 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Country

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, John Gorzewicz

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..John Gorzewicz.....

(Address)....2534 Foster av.....

15-

MAR 24 1921

....., 191.... ROBERT B KRAUTH

(Official Position or Relation.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 23, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15 1921, to March 22 1921, that I saw h.. alive on March 22 1921, and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) H. Hernandez M. D.

March 23, 1921. (Address) 722 S. Ann st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Mary Czestochowa	March 27 191...
20-UNDERTAKER	ADDRESS
Wendell Oppelsdorf	378 Mn

Spec. 6-9-19—H. P. Co.—1000 Bks.

D52238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52238

CERTIFICATE OF DEATH.

109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Rutter

(a) RESIDENCE. No. 1022 W Lombard ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Naomi Rutter

6 DATE OF BIRTH (month, day, and year) Aug 6 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Bakery supply

(c) Name of employer

9 BIRTHPLACE (city ~~or town~~) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edward L Rutter

11 BIRTHPLACE OF FATHER (city or town) Phila-
(State or country) Pa

12 MAIDEN NAME OF MOTHER Emma Reese

13 BIRTHPLACE OF MOTHER (city ~~or town~~) Balto-
(State or country) Md.

14 Informant John R Rutter
(Address) 2209 Eastern Ave

15 Filed ..... 19 ..... Registrar

MAR 24 1921 Burial Permit Olon

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1921, to March 23, 1921, that I last saw him alive on March 23, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 3/19/21
No

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Explor-atory Laparotomy

(Signed) Philibert Artigiani M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar 26 1924
20 UNDERTAKER	ADDRESS
Watkins Sahey & Sons	827 W Pratt

IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D52239

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Dalefield Ave ST.: 15 WARD)

2-FULL NAME Eberhardt Kiesner

(a) RESIDENCE. No. 3 Dalefield ave ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 18 - 1829

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	91	4 mos	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER John. Kiesner

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Emma Gregg daughter
(Address) 1931 Parkwood Ave

15 Filed MAR 24 1921 [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1920, to March 23, 1921, that I last saw h[illegible] alive on March 23, 1921, and that death occurred, on the date stated above, at Mch 24. 4 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

1. yr.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Hypostatic 4

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Gartz M. D.

. 19 (Address) 1931 Parkwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Mar. 24 1921
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 W. North Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52240

CERTIFICATE OF DEATH.

REGISTERED NO. 15172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Fannie Hobble

(a) RESIDENCE. No. 2207 Poplar Grove ST., WARD. Ohio

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Adam Hamma

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Cath. Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Chas Barchard

(Address) 725 Poplar Grove St.

15 Filed . 19 MAR 24 1921

CLERK [illegible]

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24 1921

17 I HEREBY CERTIFY, That I attended deceased from 2-26, 1921, to 3-24, 1921, that I last saw h[illegible] alive on 3-24, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Fractured Femur (Accd)

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Myocardial insuffic[illegible]

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? accident

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jeb. V. Hooper, M. D.

. 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kenicia Ohio	Mar 24 1921
20 UNDERTAKER	ADDRESS
Isaac Syfer	Woodsboro Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52241

CERTIFICATE OF DEATH.

92 D52241

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 E Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Carter

(Residence in Baltimore: No. 1514 E. Biddle St.; 38 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, January 17, 1883.
(Month) (Day) (Year)

7-AGE, 38 yrs. 2 mos. 7 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Edward E. Ritzer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline Rudolph

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Quiley S. Carter

(Address) 1514 E Biddle St

15-

MAR 24 1921 Filed ..... 191.... ROBERT I. TRAVERS Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 24, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I saw h... alive on ..... 191...,
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows: (Over)

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Robert Kehoe M. D.

March 24, 1921 (Address) 1216 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, March 28, 1921.

20-UNDERTAKER Henry Hoerth Son

ADDRESS 1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52242 ✓ D52242

CERTIFICATE OF DEATH.

36

D52242

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Miels

(Residence in Baltimore: No. St. Elizabeth's Home Chesnut Hill Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	B	S

6-DATE OF BIRTH, Nov (Month) 19 (Day), 1920 (Year)

7-AGE, ... yrs. 4 mos. 3 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Unknown
Committed to Home Dec 16/20

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-
Filed MAR 24 1921 191... ROBERT V. FRAUNFELTER ....
Registrar.
Burial Permit Issued
For city burial

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1921, to March 21 1921, that I saw h[illegible] alive on March 21 1921, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

.....
.....
Marasmus
..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Rickets
..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Frank J Ayd M. D.
Mar 22, 1921 (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
JOHNS HOPKINS HOSPITAL	
20-UNDERTAKER	ADDRESS
Commissioner Health.	MAR 24 1921

H. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

105

PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Pks.

046084 D52243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 64 D52243

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Brown.

(a) RESIDENCE. No. Howell Arcade Charlotte N.C. ST.; WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 0?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Catherine Dunbar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed MAR 24 1921 ROBERT I. KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-15-1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 6, 1921, to March 15, 1921, that I last saw h. his alive on March 16, 1921, and that death occurred, on the date stated above, at 6½ P. m.

The CAUSE OF DEATH* was as follows:

Following operation for bifocal cerebral neurolysis developed a Hemorrhage - Hypertension for years - (duration) several yrs.

CONTRIBUTORY (Secondary) Hemorrhage, cerebral 3 days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of March 10

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Emile Holman, M. D.

3-27, 1921 (Address) J. H. Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL: MAR 24 1921

20 UNDERTAKER — ADDRESS

Commissioner Health

INK—THIS IS A PERMANENT RECORD. Every item of data mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D52244 HEALTH DEPARTMENT—CITY OF BALTIMORE D52244

CERTIFICATE OF DEATH.

REGISTERED NO. C 9 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 E. Lafayette Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Marie Albrisi

(Residence in Baltimore: No. 1228 E. Lafayette ave St.; 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, MAY (Month) 31 (Day), 1863 (Year)

7-AGE 57 yrs. 9 mos. 23 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, H. McDonough

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Fanny McDonough.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert F. Albrisi

(Address) 1228 E. Lafayette Ave.

15-

Filed MAR 24 1921 ROBERT A. BRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from FEB 28 1921, to MAR 23 1921,

that I saw HER alive on MAR 23 1921,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute dilated heart

(Duration) hrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. 6 mos. ds.

(Signed) O. H. Dunkle M. D.

MAR 23, 1921 (Address) 928 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. | DATE OF BURIAL, March 26, 1921

20-UNDERTAKER George J. Ruth | ADDRESS 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D52245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52245

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 S. Schroeder St. - ST.: 18 WARD)

2-FULL NAME Catherine Gannon

(a) RESIDENCE. No. 123 S. Schroeder St. - ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Gannon

6 DATE OF BIRTH (month, day, and year) Nov 1st 1873

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael McGloin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Gannon
(Address) 123 S. Schroeder St.

15 FILED MAR 24 1921 BURIAL PERMIT ISSUED

Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23. 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1921, to March 23, 1921, that I last saw h.r alive on March 23, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation.
(Valvular Heart Disease)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Examination

(Signed) Chas. Norton, M. D.

3/24, 1921 (Address) 858 N. Longwood St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mar 26th 1921
20 UNDERTAKER	ADDRESS
John J. Cavan Son	901 Hollins

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D52246

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2007 McKean Ave ST.: 15th WARD)

2-FULL NAME Richard Martin Heemann

(a) RESIDENCE. No. 2007 McKean Ave ST.: 15 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9m yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 6, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	✓	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Walter W Heemann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Alice R Martin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Walter W Heemann
(Address) 2002 McKean Av

15 Filed MAR 24 1921 ROBERT I KRAUTER Registrar

Burial Permit Oliver

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 6. 1921, to Mar 23, 1921, that I last saw h[illegible] alive on Mar 23, 1921, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. 18 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Joseph T. Herring, M. D.

19 (Address) Walbrook 1800 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuels Cem	March 25
20 UNDERTAKER	ADDRESS
Sues Heemann	826 Brom

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.52247 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.52247

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3708 ashburton ave. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore J. Foster

(a) RESIDENCE. No. 3708 Ashburton ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word)
M.	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Sarah E. Foster.

6 DATE OF BIRTH (month, day, and year) Nov 15-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Sergt Police 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Pol Dept

9 BIRTHPLACE (city or town) (State or country) King William Co Va

PARENTS

10 NAME OF FATHER Phil F. Foster.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eleanor Douglas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Sarah E. Foster. (Address) 3708 Ashburton Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

MAR 24 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1921

17 I HEREBY CERTIFY, That I attended deceased from ~~about~~ Feb 18, 1921, to March 23, 1921, that I last saw him alive on March 22, 1921, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? only physical examination and symptoms.

(Signed) J. F. Shemwell, M. D.

19 (Address) 2226 Madison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Mar 25-21
20 UNDERTAKER	ADDRESS
Bertram Cole	1723 N. Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D.52248

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52248

CERTIFICATE OF DEATH.

154

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 West 25th ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Uttley

(Residence in Baltimore: No. 11 West 25th St.; for some years yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (*Write* the word.) widow

6-DATE OF BIRTH, Do not know exact date (Month) (Day) (Year)

7-AGE, 85 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: no occupation
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Philadelphia Pa

PARENTS.

10-NAME OF FATHER, Kirby

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Julia Moore

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna G. Brady

(Address) 1006 N. Calvert St.

15- Robert P. Harrison, Registrar.

MAR 24 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3rd (Month) 23rd (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 13 1921, to March 23rd 1921, that I saw h.r alive on March 23rd 1921, and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows:

Old age

general debility

Bedfast (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Amanda L. Morris M. D.

, 191... (Address) No 10 West 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Wood Cem. N.Y. DATE OF BURIAL, Mch 26, 1921

20-UNDERTAKER John Mitchell ADDRESS 1201 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.52249 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.52249

CERTIFICATE OF DEATH. 150

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 Rasiter ave ST.: 27 WARD)

2-FULL NAME Hugh. a Dietz Jr.

(a) RESIDENCE. No. 512 Rusiter Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant Son

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Hugh a Dietz

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary M Pyle

13 BIRTHPLACE OF MOTHER (city or town) Hagerstown
(State or country) Md

14 Informant Mrs Dietz
(Address) 512 Rossiter Ave, Govans, Md

15 Filed Robert J Harrison, Registrar

MAR 24 1921 Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1921, to Mar. 23, 1921, that I last saw him alive on Mar. 23, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hess, M. D.

3-23 1921 (Address) 5200 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemy	Mch 25 1921
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52250 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52250

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 401 East 31st St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Valentina A. Miller

(a) RESIDENCE. No. 401 East 31st St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired dd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Skrigg

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Ellen A. Miller

(Address) 401 E. 31st St. Balto Md.

15 Filed ..... 19 Robert F. Harrison, Registrar

MAR 24 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1920, to March 24 1921, that I last saw h[illegible] alive on March 23rd 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. A. Fair M. D.

3/24 21 (Address) 12 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	March 26 1921

20 UNDERTAKER	ADDRESS
John O. Mitchell	120 W. Fayette St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 52251 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52251

CERTIFICATE OF DEATH. 43

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1233 W. Balto ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Creigh

(a) RESIDENCE. No. 1233 W. Balto. St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Jan. 15-1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52 years.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harrisburg (State or country) Pa.

PARENTS

10 NAME OF FATHER John Creagh

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Bridget O'Donnell

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant T. Hebbitt (Address) 1233 W. Balto st

15 Filed 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22/21. 19

17

I HEREBY CERTIFY, That I attended deceased from Mch 1, 1921 to March 22 1921

that I last saw her alive on March 21 1921

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma breast.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 9 months ago.

Was there an autopsy? No.

What test confirmed diagnosis? Microscope

(Signed) J. B. Summers, M. D.

3-24-1921 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	3-25 1921
20 UNDERTAKER H. Brauning & Son	ADDRESS 517 N. Schroeder St

MAR 24 1921

Burial Permit Blank

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of infor-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-52252 ✓ D-52252

CERTIFICATE OF DEATH.

D-40

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 N. Fulton Ave. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvia Anna Hutton.

(a) RESIDENCE. No. 1509 N. Fulton Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Henry Hutton

6 DATE OF BIRTH (month, day, and year) June 2nd 1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
47	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Christian Gold

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hild.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant Thomas F. Hutton
(Address) 1504 W. Baltimore ave.

15 Filed ..... 19.. Robert P. Harrison, Registrar
Burial Permit Clerk.

MAR 24 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27th, 1918, to March 23, 1921, that I last saw h.e alive on March 22nd, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 14-1918

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Wm. Louis Conrad Bode M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Mch 26 1921
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52253 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52253

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2316 E Northern St. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Milnor Alexander

(a) RESIDENCE. No 2316 E. Northern ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hattie Alexander

6 DATE OF BIRTH (month, day, and year) Sept 29 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER James Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mulvaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Chas L Alexander
(Address) 2316 E Northern

15 Filed Robert P. Harri[illegible] Registrar

MAR 24 1921

Burial Permit Cl[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1921

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1921, to March 22, 1921, that I last saw h[illegible] alive on March 22, 1921, and that death occurred, on the date stated above, at 1:30 PM.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. S. Gray, M. D.

3/23, 1921 (Address) 677 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carondelet Mem

DATE OF BURIAL Mar 24 1921

20 UNDERTAKER A. Lenhardt & Son

ADDRESS North St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52254 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52254

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3704 Park Heights Ave (Hospital) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Simpkins

(a) RESIDENCE. NO. 3704 Park Heights Ave St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Simpkins

6 DATE OF BIRTH (month, day, and year) Oct 5-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Smithfield Pa

PARENTS

10 NAME OF FATHER Geo Mc Bannan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Betsy Gerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) John H Simpkins 3704 Park Hts Ave

15 Filed MAR 24 1921 19 Robert P Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1921

17 I HEREBY CERTIFY, That I attended deceased from June 19 19 to March 24 19 21 that I last saw h[er] alive on March 23d 19 21 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

10 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual clinical

(Signed) Benjn M Stone M. D.

19 (Address) 1435 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond. Va	Mar 25 1921
20 UNDERTAKER	ADDRESS
Wm J Tickner & Son	N. Y Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Ella Miller)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52255 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52255

CERTIFICATE OF DEATH. X 88

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Md. General Hospt St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Miller

(a) RESIDENCE. NO. Childs, Maryland ST. WARD. Childs Station Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed or divorced (or) WIFE of James F Miller

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Zion Maryland

PARENTS

10 NAME OF FATHER Henderson Vaupelt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant A. F. Abrmathy (Address) Cherry Hill Md.

15 Filed MAR 24 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24. 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/18, 1921, to 3/24, 1921, that I last saw her alive on 3/24, 1921, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Residence

Did an operation precede death? Yes Date of 3/23/21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M. D.

, 19 (Address) Md. General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Childs Sta. Md	Mar 27 1921
20 UNDERTAKER Wm J. Tuckwell Sons	ADDRESS N Y Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.52256

HEALTH DEPARTMENT---CITY OF BALTIMORE

D.52256

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED NO. C. 79

CITY OF BALTIMORE: (No. 5 Oakley Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine L. Brockney

(Residence in Baltimore: No. 5 Oakley Ave St.; 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Feb. 16 (Month), (Day), 1836 (Year)

7-AGE: 85 yrs. 1 mos. 6 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Phila Pa.

PARENTS

10-NAME OF FATHER: Jacob Harp

11-BIRTHPLACE OF FATHER (State or country): Pottsville Pa

12-MAIDEN NAME OF MOTHER: Mary E. Bluett

13-BIRTHPLACE OF MOTHER (State or country): Pottstown Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): C. W. Harvard

(Address): 3 Chelsea Place

15- Robert F. Harrison,

Filed, 191 Burial Permit Clerk REGISTRAR

AR 24 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 22 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1914, to, Mar 22 1921, that I saw h[er] alive on Mar 22 1921, and that death occurred, on the date stated above, at 5.40 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 6 yrs. 3 mos. 21 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), John D Seibert M. D.

Mar 22 1921 [Address] 485 Park Ave City

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Mar. 25, 1921

20-UNDERTAKER: J. Ed Bruning Co. ADDRESS: 817 Edmondson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52257 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52257

CERTIFICATE OF DEATH.

1463 X131

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Cobb

(a) RESIDENCE. No. Ruffin N.C. ST., WARD. Ruffin N. C.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Linnie Cobb

6 DATE OF BIRTH (month, day, and year) Mch 28-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER James K. Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary Bugabee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed Robert P. Harrison, Registrar

APR 24 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1921, to Mch 23, 1921, that I last saw her alive on Mch 23, 1921, and that death occurred, on the date stated above, at 6:55 P. m.

The CAUSE OF DEATH* was as follows:

Ovarian Cyst, multilocular, infected —

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cachexia —

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Oct. 1920. also Feb 21. 1921

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy —

(Signed) L. Rowland, M. D.

3-24 1921 (Address) Johns Hopkins Hosp. —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ruffin N. C.	Mch 25 1921

20 UNDERTAKER H. E. Hughes ADDRESS 1st & Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause Unknown

Spec.—6-9-19—H. P. Co.—1000 Bks.

Stone

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52258

64 D52258

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4310 Springdale Ave WARD 24)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Stone

(a) RESIDENCE. No. 4310 Springdale Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard E. Stone

6 DATE OF BIRTH (month, day, and year) Feb. 8/1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md.

PARENTS

10 NAME OF FATHER Joseph Lamb.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Charlotte McConnick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie Tschudy. (Address) 4310 Springdale Ave

15 MAR 25 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23. 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1920, to March 23, 1921, that I last saw h[illegible] alive on March 22, 1921, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Hemiplegia

following cerebral haemorrhage

Fracture neck of femur

(12 weeks) (duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Duration

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical evidence

(Signed) Fernadge W. Mitchell, M. D.

, 19 (Address) 704 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	3/26 1921

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St

[illegible] LOTTIE I. [illegible]
Burial Permit Clerk

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Any item of information not known may be left blank.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fell out of rocking chair
Physician states that
in his estimation the
cerebral hemorrhage and
condition of kidneys was
primary cause of death in
reference to fall

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52259

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Putty

(a) RESIDENCE. No. 227 W. Hill St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Putty

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) New Kent Co. (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Putty

11 BIRTHPLACE OF FATHER (city or town) New Kent Co (State or country) Virginia

12 MAIDEN NAME OF MOTHER Norah Price

13 BIRTHPLACE OF MOTHER (city or town) New Kent Co (State or country) Virginia

14 Informant David Putty (Address) 226 Oxford St.

15 MAR 25 1921 [illegible] Registrar

Burial Permit Oler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to March 23, 1921, that I last saw her alive on March 23, 1921, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Yes Date of March 23, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Signs and Symptoms, Operation

(Signed) F. C. Marino, M. D.

3,23, 1921 (Address) St. Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Kent Co, Va	March 25 1921
20 UNDERTAKER	ADDRESS
John H Owens	538 Dolphin

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52260

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1523 Mt. Cullough ST. 14 WARD)

REGISTERED No. C

2-FULL NAME Mary C. Jones

(Residence in Baltimore: No. 1523 Mt. Cullough St.: yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

6 9 17

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June 5, 1920
(Month) (Day) (Year)

7-AGE, yrs. 9 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Warren Jones

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary Hall

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Jones

(Address) 1523 Mt. Cullough St.

15- Filed MAR 25 1921, 191.. ROBERT F. KRAUTH Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) No History of any infections or contagious diseases

(Duration) yrs. mos. ds.

(Signed) J. D. Hennessey M. D.
(Coroner.)

March 23 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Mar. 25 1921

20-UNDERTAKER Edward Ruggold — ADDRESS 1463 Carey St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52261

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Taylor

(a) RESIDENCE. No. 1147 N. Fremont ave. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not recorded

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Edmond Gaskins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Louise Bracken

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records
(Address) M.T.H.

15 Filed MAR 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1921, to March 24, 1921, that I last saw her alive on March 23, 1921, and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) M. L. Gupey, M. D.

3-24-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mar 27 1921
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 Carey St

Registrar

Burial Permit Clerk

CAUSE OF DEATH is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52262

151

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2333 E Monument St.; ? WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hanna

(a) RESIDENCE. No. 2333 E Monument St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 24 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward J. Hanna

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Tarit

13 BIRTHPLACE OF MOTHER (city or town) Balty.
(State or country) Md.

14 Informant Edward J. Hanna
(Address) 2333 E. Monument St

15 MAR 25 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1921

I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to March 24, 1921, that I last saw him alive on March 24, 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Both

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

3/25/21 (Signed) William H Groves, M. D.

19 (Address) 801 E Fedrwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	3-27 19 21
20 UNDERTAKER	ADDRESS
H. Thaw Gebhardt	1 E Monument

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

052263

HEALTH DEPARTMENT—CITY OF BALTIMORE

052263

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia McHenry

(a) RESIDENCE. NO. 1106 Greenmount Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER Capt. Thos. Mullen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER Sarah Moran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Hospital Records,

(Address): New City Hospital.

15 Filed MAR 25 1921 LOWERY & KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1921, to March 23, 1921,

that I last saw her alive on March 23, 1921,

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) P. H. Eaman, M. D.

3/24/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar. 26, 1921

20 UNDERTAKER H. C. Niedefeld ADDRESS 914 Greenmount Av

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

Dr Hearn

D52264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52264

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 438 N. Luzerne ST.; 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs F. Rever

(a) RESIDENCE. No. 438 N. Luzerne ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Elizabeth Rever

6 DATE OF BIRTH (month, day, and year) Mar 1 52

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	-	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 006

(b) General nature of industry, business, or establishment in which employed (or employer) Blacksmith

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Rever

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Buchman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Rever
(Address) 438 N. Luzerne ~~Mother's Parents~~

15 Filed MAR 25 1921 Burial Permit [illegible] Other

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1921, to March 23, 1921, that I last saw him alive on March 23, 1921, and that death occurred, on the date stated above, at 12 55 P. m.

The CAUSE OF DEATH* was as follows:

Paralisis

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Hardening of arteries & High Blood Pressure (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yr

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. A. Hearn M. D.

3/24 1921 (Address) 2600 E. 30th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	3/26 1921
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Aisquith

nation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Hemorrhage

Spec.—8-24-14—M. & T.—2000 Bks.

D52265 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D52265

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 N. Vincent St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Smith

(Residence in Baltimore: No. 1626 N. Vincent St.; yrs. 5 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct. 19, 1720 (Month) (Day) (Year)

7-AGE, yrs. 5 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Saml. Smith

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Carrie Brayton

13-BIRTHPLACE OF MOTHER (State or Country), Balto., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Saml. Brayton

(Address) 1626 N. Vincent St.

15- Filed MAR 25 1921, 191... ROBERT J. KRAMER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 23, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 20 1921, to Mar. 22 1921, that I saw her alive on March 22 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) John D. Quinn M. D.

Mar 23, 1921 (Address) 1507 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn — DATE OF BURIAL, MAR 25 1921

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

D52266

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D52266

80

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 W Lexington ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Colbert

(Residence in Baltimore: No. 1529 W Lexington St. 4 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	white	widower

6-DATE OF BIRTH, Sept 15, 1847 (Month) (Day) (Year)

7-AGE, 73 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chair Bruilder
(b) General nature of industry, business, or establishment in which employed (or employer): 056

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Lewis N Colbert

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catherine O'Brien

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Rosarity

(Address) 1529 W Lexington

15- Filed MAR 25 1921 ROBERT J. KRAUTER Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 24, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 3 1921, to Mch 24 1921, that I saw him alive on Mch 23 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. Sudden mos. ..... ds.

CONTRIBUTORY (Secondary) Arteria sclerosis

(Duration) ..... yrs. four years mos. ..... ds.

(Signed) M Benns and Hood M. D.

Mch 25, 1921. (Address) 626 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	March 26 1921
20-UNDERTAKER	ADDRESS
Thos M Fahey & Son	827 W Lexington St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52267

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Funeral Home 1923 REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jessie Beale

(a) RESIDENCE. No. 18 Evergreen Ave ST. Hamilton WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Beale.

6 DATE OF BIRTH (month, day, and year) Dec 3 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fortress Monroe Virginia

PARENTS

10 NAME OF FATHER Thomas G Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Cochran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant William H. Beale

(Address) 18 Evergreen ave Hamilton

15 MAR 25 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar. 17, 1921, to March 24, 1921, that I last saw h er alive on March 24, 1921, and that death occurred, on the date stated above, at 8:20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ureteral Calculus

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ?

(Signed) W H Wade, M. D.

. 19 (Address) Funeral Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	March 26 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 Monroe Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52268 HEALTH DEPARTMENT—CITY OF BALTIMORE D52268

CERTIFICATE OF DEATH. X 28

1-PLACE OF DEATH US. Public Health Hosp. #56 REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore St. Md. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A. O'Conner

(a) RESIDENCE. No. US. Public Health Hosp. #56 35 WARD. Phila. Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33 yrs.	---	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) ---- 009

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosebrock Registrar

(Address) US. PHS. Hosp. #56 Ft. McHenry Md

15 MAR 25 1921 ROBERT J. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28 1921 to March 24 1921, that I last saw him alive on March 24 1921, and that death occurred, on the date stated above, at 9 p.m. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary & far advance active.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of ----

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Thomas R. Paynes Senior Surgeon U.S.P.H.S.

, 19 (Address) US. PHS. Hops. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philada Pa — DATE OF BURIAL Mar 25, 1921

20 UNDERTAKER S. Friedman & Bro — ADDRESS 127 E Balto St

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52269 HEALTH DEPARTMENT—CITY OF BALTIMORE D52269

CERTIFICATE OF DEATH. X 9

1-PLACE OF DEATH U.S. Public Health Service Hosp. #56 REGISTERED NO.....

CITY OF BALTIMORE: (No. Port McHenry Baltimore Md. ST.: 24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James O Howard

(a) RESIDENCE. No. U.S. Public Health Service Hosp. #56 WARD. Nonresident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 4 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Krenbuhl Registrar
(Address) U.S. P.H.S. Hosp. #56 P. McHenry Md.

15 Filed MAR 25 1921 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19 1921, 19..., to March 23 1921, that I last saw him alive on March 23 1921, 19..., and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam. Clinic report

(Signed) Thomas R. Payne M. D.

, 19 (Address) U.S. P.H.S. Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — DATE OF BURIAL Mar 25 1921

20 UNDERTAKER J. Swinson & Bro — ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

952270

HEALTH DEPARTMENT—CITY OF BALTIMORE

952270

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 Pennington Ave ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bronislaw Berger

(a) RESIDENCE. No. 203 pennington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 00

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wladyslaw Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ksawerya Faulkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Th. Berger
(Address) 203 Pennington Ave

15 FILED MAR 25 1921 ROBERT F. HEALY Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23rd 1921, to March 23rd 1921, that I last saw h. alive on March 23rd 1921, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. E. Horton, M. D.

, 19 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross R. C. Cem	March 25 1921
UNDERTAKER, Wm Faulkowski	ADDRESS 1618 Eastern

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D6512
D52271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52271

CERTIFICATE OF DEATH.

X 9

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dorothy Elizabeth Graefe

(a) RESIDENCE. No. Owings Mills, Md. ST., WARD. Owings Mills Md

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~ John & Wilhelmina Graefe. (Parents)

6 DATE OF BIRTH (month, day, and year) May 2, 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dnolia

PARENTS

10 NAME OF FATHER John Graefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Wilhelmina Beyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed MAR 25 1921 ROBERT J. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1921, to March 24, 1921, that I last saw her alive on March 24, 1921, and that death occurred, on the date stated above, at 8-5 A. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Laryngeal)

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 3/7/21

Was there an autopsy? Yes

What test confirmed diagnosis? Cultures

(Signed) W. T. Davison, M. D.

3-24, 1921 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	March 26 1921
20 UNDERTAKER	ADDRESS
J. F. Ehrie	Reisterstown Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form 6-9-19—H. P. Co.—1000 Bks.

D52272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52272

CERTIFICATE OF DEATH.

X 1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. St.: 4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Snyder

(a) RESIDENCE. No. Roslyn Md St., Ward. Roslyn Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1st 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20 years	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery Store

(c) Name of employer Mrs Lys Md Mac Langton Roslyn Md

9 BIRTHPLACE (city or town) (State or country) Roslyn Md

PARENTS

10 NAME OF FATHER Daniel Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Elizabeth Klodt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daniel Snyder (Address) Roslyn Md.

15 Filed MAR 25 1921 ROBERT E. KRAUTER Registrar Burial Permit Oked

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-16, 1921, to 3-24, 1921, that I last saw h. alive on 3-24, 1921, and that death occurred, on the date stated above, at 4:10 A m.

The CAUSE OF DEATH* was as follows:

1. Typhoid Fever

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Perforation with acute Diffuse Peritonitis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 3-16-21

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture &c

(Signed) Geo. V. Hooper, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem (Roslyn Md)	Mar 26 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52273

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 S. Sharp St. ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Meyers

(a) RESIDENCE. No. 1226 S. Sharp St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Meyers

6 DATE OF BIRTH (month, day, and year) May 7" 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman (J.O. Wright 466)

(b) General nature of industry, business, or establishment in which employed (or employer) Commission Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER William Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Rachel Meyers

(Address) 1226 S. Sharp St.

15 MAR 25 1921 ROBERT I. KRAUSE Registrar Burial Permit Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25" 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/23, 1921, to 3/25, 1921, that I last saw he alive on 3/24, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. E. Lynch, M. D.

, 19 (Address) 710 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 28th 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Bolton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D52274

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52274

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. North Ave.,& Appleton St ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sergt. Bernard J. Landers

(Residence in Baltimore: No. 123 N. Fulton Ave. St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, January (Month) 19" (Day), 1873 (Year)

7-AGE, 48 yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 061
(a) Trade, profession, or particular kind of work: Sargeant Baltimore
(b) General nature of industry, business, or establishment in which employed (or employer): Police Department

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Landers

11-BIRTHPLACE OF FATHER (State or Country). Dublin, Ireland

12-MAIDEN NAME OF MOTHER Anne Reilly

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret Landers

(Address) 123 N. Fulton Ave.

15- Filed MAR 25 1921, 191.... ROBERT J. LAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 23" (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

15 minutes (Duration), ...yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arterial hypertension

2 (Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

March 24, 1921. (Address) 2802 E. Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral Cem	March 26 1921
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bond St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr doctors office thenmorning developed central
and death resulted in 15 minutes.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Bach

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52275 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D52275

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 S Catherine ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F Bach

(a) RESIDENCE. NO. 101 S Catherine ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 9-1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer in foundry

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Bach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Cotter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elkridge Md

14 Informant Andrew F. Bach
(Address) 101 S. Catherine St.

15 MAR 25 1921 ROBERT A KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to March 23, 1921, that I last saw h[illegible] alive on March 23, 1921, and that death occurred, on the date stated above, at 9 05 m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert Curtis M. D.

1921 (Address) 215 Hillen Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge Md.	Mar 26 21
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state information should be given on back of certificates. See instructions on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52276 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52276

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital REGISTERED NO.....

CITY OF BALTIMORE: (NO. ..... ST.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Odell

(a) RESIDENCE. NO. Harmans Md. ST., ... WARD. Harmans Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 16 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Robert Odell

6 DATE OF BIRTH (month, day, and year) — 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36			

8 OCCUPATION OF DEECEASED

(a) Trade, profession or particular kind of work Housewife (37)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Chas Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Liza Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Hospital - Records (Address)

15 Filed Mar 26 1921 Robert P. Harris Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25- 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1921, to March 25, 1921, that I last saw her alive on March 25, 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre
Acute dilatation of heart.

(duration) 12 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Post Operative thyroid - Exposure (duration) ..... yrs. ..... mos. 10 days

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of March 24, 1921

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Cyrus F. Hoxie, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md.	3-25 1921
20 UNDERTAKER E & B Hale	ADDRESS 115 E West St

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D, 52277

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52277

CERTIFICATE OF DEATH.

90

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 S. Fulton Ave ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Jeanette Beaufelter

(Residence in Baltimore: No. 15 S. Fulton Ave St.; one yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, July (Month) 9 (Day), 1850 (Year)

7-AGE, 70 yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Frederick Md

PARENTS.

10-NAME OF FATHER, Henry Fraley

11-BIRTHPLACE OF FATHER (State or Country), Frederick Md

12-MAIDEN NAME OF MOTHER Elizabeth Fagan

13-BIRTHPLACE OF MOTHER (State or Country), Frederick Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Irene Steer

(Address) 15 S. Fulton Ave

15-

Robert P. Harrison

Filed ....., 191.....

Registrar.

MAR 26 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 24, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 10 1921, to March 24 1921, that I saw her alive on March 23 1921, and that death occurred, on the date stated above, at 3.15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(Duration) yrs. mos. 14 ds.

(Signed) [illegible] M. D.

March 24, 1921 (Address) 1733 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem Frederick Md	Mar. 28, 1921.
20-UNDERTAKER Harry A Dunacost	ADDRESS 4204 Ridgewood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be carefully supplied. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

D. 52278

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52278

CERTIFICATE OF DEATH.

1205

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 E 22nd St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward W. Booth

(Residence in Baltimore: No. 426 E. 22nd St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, April (Month) 21 (Day), 1869 (Year)

7-AGE,	If LESS than 1 day,
51 yrs. 11 mos. 3 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Co. Md

PARENTS.

10-NAME OF FATHER, John G. Booth

11-BIRTHPLACE OF FATHER (State or Country), Chest. Co. Pa

12-MAIDEN NAME OF MOTHER Ida E. Matthews

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. B. Stringer

(Address) 426 E 22nd St

15-

MAR 26 1921

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 21st 1921, to March 24 1921, that I saw h[im] alive on Mch 24th 1921, and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 4 yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) August Horn M. D.

, 1921, (Address) 405 E 22nd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Chestnut Grove Presbyterian Church Cemetery Balto Co Md

DATE OF BURIAL, MAR 27 1921

20-UNDERTAKER JOHN F. DENNY

ADDRESS 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Booth

D. 52278

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52278

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 E 22nd ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward W. Booth

(Residence in Baltimore: No. 426 E. 22nd St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, April (Month) 21 (Day), 1869 (Year)

7-AGE, 51 yrs. 11 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore Co. Md

PARENTS.

10-NAME OF FATHER, John G. Booth

11-BIRTHPLACE OF FATHER (State or Country), Chest. Co. Pa

12-MAIDEN NAME OF MOTHER Ida E. Matthews

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... C. B. Shuinger

(Address) 426 E 22nd St

15-

MAR 26 1921

Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 21st 1921, to March 24 1921, that I saw h[im] alive on Mch 24th 1921, and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ....yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) August Horn M. D.

....., 191.., (Address) 426 E 22nd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Chestnut Grove Presbyterian Church Cemetery Balto Co Md

DATE OF BURIAL, MAR 27 1921

20-UNDERTAKER JOHN F. DENNY

ADDRESS 715 LIGHT ST.

IMPORTANT.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 52279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52279

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST.: 5 92 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Carter.

(Residence in Baltimore: No. 262 Colvin St.; yrs., mos. ds.)

GE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col'd	Married

6-DATE OF BIRTH, Unknown, 187[illegible]
(Month) (Day) (Year)

7-AGE, 47 yrs. mos. ds. Or Widowed If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Philip Carter

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Helen Barksdale

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Carter

(Address) 262 Colvin St

15-

Filed ....., 191....

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

MAR 26 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24, 1919.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Probably) Pulmonary
Tuberculosis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

July 26, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cem	July 26, 1921.

20-UNDERTAKER	ADDRESS
Harry A. Woodey	1725 Orleans St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52280

X 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. St.) (No. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Bldek

(a) RESIDENCE. NO. Union Mills St.. WARD. Union Mills Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Union Mills Maryland

PARENTS

10 NAME OF FATHER James A. Black

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Harvey Bankard Westminster Md

15 Filed Robert P. Harris Registrar

MAR 26 1921

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 / 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7th, 1921, to March 25, 1921, that I last saw him alive on March 25, 1921, and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ~~liver~~ left lung with Exudate in Pleura

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dyspnea

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Union Mills Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical X-Ray Laboratory

(Signed) Philibert Antigiani M. D.

(Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Silver Run	March 28 1921
20 UNDERTAKER	ADDRESS
H Bankard & Sons	Westminster

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.52281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52281

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2614 N. Charles ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Myers

(Residence in Baltimore: No. 2614 N. Charles St.; 6 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 31 (Day), 1839 (Year)

7-AGE, 81 yrs. 1 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Companion
(b) General nature of industry, business, or establishment in which employed (or employer): at Home 086

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Ephrian Myers

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Stackman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. R. Bevan

(Address) 2614 N. Charles St

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

MAR 26 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 25th (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 11 1921, to March 25 1921, that I saw her alive on March 24 1921, and that death occurred, on the date stated above, at 4:50 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 0 yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ? yrs. mos. ds.

(Signed) J. Cyril Estes M. D.

3/25, 1921 (Address) 2614 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hancock Md

DATE OF BURIAL, Mar 26, 1921

20-UNDERTAKER A. S. Marshall

ADDRESS 339 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

205282 HEALTH DEPARTMENT—CITY OF BALTIMORE 205282

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Agnes Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Kidd

(a) RESIDENCE. NO. 526 N. Callington Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER — Kidd

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Gist Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs F. W. Gessford
(Address) 1118 W. Lafayette Ave

15 Filed Mar 26 1921 Robert P. Harrison, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25 1921

17

I HEREBY CERTIFY, That I attended deceased from 3-12, 1921, to 3-25, 1921, that I last saw h.. alive on 3-25, 1921, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma – glands of neck. Metastases to lungs + mediastinum

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis – cardiac failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Ga.

Did an operation precede death? Yes Date of 3-23-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McKeag, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar. 28 1921
20 UNDERTAKER A. J. Marshall	ADDRESS 3539 Gall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-19—H. P. Co.—1000 Bks.

D. 52283 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52283

146 52

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 791

CITY OF BALTIMORE: (No. Johns Hopkins Hosp St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Jackson

(a) RESIDENCE. NO. 1102 Woodyear Et ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 7 years yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Jackson

6 DATE OF BIRTH (month, day, and year) June 16-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Hamilton Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record (Address) J. H. H.

15 Filed MAR 26 1921 Robert P. Harrison, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to March 25, 1920, that I last saw her alive on March 25, 1921, and that death occurred, on the date stated above, at 3.00 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical findings

(Signed) Edward C. Vandam M. D.

3. 25, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Orange Grove Cemetery	MAR 26 1921

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Grubitz)

D-52284 HEALTH DEPARTMENT--CITY OF BALTIMORE D-52284

CERTIFICATE OF DEATH

64

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 407 S. Mount St. 19 WARD) Registered No. C

(If death occured in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Taylor Grubitz

(Residence in Baltimore: No. 407 S. Mount St.) Sex M. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M.

4-COLOR OR RACE: W

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: September 5, 1878 (Month) (Day) (Year)

7-AGE: 43 yrs. 6 mos. 19 ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing

9-BIRTHPLACE (State or country): Hungary.

PARENTS

10-NAME OF FATHER: Stephen Grubitz

11-BIRTHPLACE OF FATHER (State or country): Hungary

12-MAIDEN NAME OF MOTHER: Lucy Saur

13-BIRTHPLACE OF MOTHER (State or country): Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Grubitz

(Address) 407 S Mount St

15

MAR 26 1921 Robert P. Harrison, 191

Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March 24, 1921 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from March 16, 1921, to March 24 1921.

that I saw h[illegible] alive on March 23, 1921.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Nephritis - Cerebral hemorrhage. 10 days

(Duration) 5 yrs. mos. d

Contributory (SECONDARY) Cirrhosis

(Duration) yrs. 7 mos. d

(Signed) Fernando R. Nicholas M.

March 24, 1921 (Address) 904 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... d

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral

DATE OF BURIAL: MAR 28 1921

20-UNDERTAKER: MR. & MRS. N. S. FINK, FUNERAL DIRECTORS

ADDRESS: 1836 W. PRATT STREET.

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 52285 (Further) HEALTH DEPARTMENT--CITY OF BALTIMORE D. 52285

CERTIFICATE OF DEATH

8/20

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 2810 Guilford Av. ST. 12 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Stanley B. Prather

(Residence in Baltimore: No. 2810 Guilford Av St. 23 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M | 4 COLOR OR RACE: W | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: March 5th, 1861 (Month) (Day) (Year)

7 AGE: 60 yrs. — mos. 20 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Electrical Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

9 BIRTHPLACE (State or country): Cincinnati Ohio

PARENTS

10 NAME OF FATHER: Charles Prather

11 BIRTHPLACE OF FATHER (State or country): Dr Kentucky America

12 MAIDEN NAME OF MOTHER: Catharine Carman

13 BIRTHPLACE OF MOTHER (State or country): Do not know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Scott Arnold
(Address) 2810 Guilford Av

15 Filed MAR 26 1921, 191 Robert P. Harrison, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 25th, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1920, to March 25 1921, that I saw h[illegible] alive on March 24th, 1921, and that death occurred, on the date stated above, at 8:25 a m.
The CAUSE OF DEATH*, was as follows:
Arteriosclerosis & Chronic Myocarditis
(Duration) Unknown yrs. ..... mos. ..... ds
Contributory (SECONDARY) Unknown
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Josephine Bruce M. D.
March 26, 1921 (Address) 2846 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cem. | DATE OF BURIAL: Mar 27, 1921

20 UNDERTAKER: Geo J Smith | ADDRESS: 1001 N. Gazette

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52286 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52286

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 544 Moore ST.: 17 WARD)

2-FULL NAME John Campbell

(a) RESIDENCE No. 544 Moore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER John Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Harriet Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Campbell (Address) 544 Moore St

15 MAR 26 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5 - 1921, to March 24 1921, that I last saw him alive on March 23, 1921, and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Bright's Complication

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bright's Disease + Complication

Disease (duration) yrs. 4 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. G. W. Kennard, M. D.

3-24-1921 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Bur	March 28 1921
20 UNDERTAKER	ADDRESS
David Easton	916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

#6241 D. 52287 — 122 D. 52287

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May Dougal

(a) RESIDENCE. No. 631 Greenwillow St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ Life ~~mos.~~ ~~ds.~~ How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Adelle Harris (Mother)

6 DATE OF BIRTH (month, day, and year) Aug 16, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City.

PARENTS

10 NAME OF FATHER Mack Dougal.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Adelle Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Johns Hopkins Hospital Records.

(Address) ~~Robert P. Harrison,~~

Filed MAR 26 1921, 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1921, to March 24, 1921, that I last saw her alive on March 24, 1921, and that death occurred, on the date stated above, at 5 00 A m.

The CAUSE OF DEATH* was as follows:

Cyclonephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Microscope

(Signed) W Davison, M. D.

3-24, 1921 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	March 26 1921
20 UNDERTAKER	ADDRESS 916
Daniel Eastes	Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52288 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52288

CERTIFICATE OF DEATH. + 102

1-PLACE OF DEATH University Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E Bayne

(a) RESIDENCE. No. Towson Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Augusta C Bayne

6 DATE OF BIRTH (month, day, and year) Oct. 24-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Bayne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Olivia A. Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Augusta C. Bayne
(Address) Allegheny Ave Towson

15 Filed ..... 19 Robert P Harrison Registrar

MAR 26 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1921, to March 24, 1921, that I last saw him alive on March 24, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Perforated gastric ulcer

Subphrenic abscess

General Peritonitis

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 28, 192

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Cyrus J Horine, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 3/28/1921

20 UNDERTAKER William Cook — ADDRESS 30 E North Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52289 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52289

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Pitcher St.: 16 WARD)

2-FULL NAME Martha J. Braun

(a) RESIDENCE. No. 1404 Pitcher St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of James M. Braun

6 DATE OF BIRTH (month, day, and year): Dec 24 1833

7 AGE: Years 87 Months 2 Days — If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: Wm Stansbury

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md

12 MAIDEN NAME OF MOTHER: Eliza Lycette

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: Mrs. G. A. Perger
(Address) 1404 Pitcher St

15 Filed MAR 26 1921 19 Robert P. Harris Registrar

Burial Permit [redacted]

Below 2757 W. Saratoga

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1921, to March 23 1921, that I last saw h[illegible] alive on March 23 1921, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. C. Ulman, M. D.

3/24/21 (Address) 2757 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: March 25 21

20 UNDERTAKER: William Cook — ADDRESS: 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52290

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 N. Broadway ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert William Stone

(a) RESIDENCE. No. 1705 N. Broadway ST., 8 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 52 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: May Matilda Stone

6 DATE OF BIRTH (month, day, and year): Dec-6-1861.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sea Captain.

(b) General nature of industry, business, or establishment in which employed (or employer): Master Mariner.

(c) Name of employer: Bethlem Steel Co.

9 BIRTHPLACE (city or town) (State or country): Great Yarmouth, England

PARENTS

10 NAME OF FATHER: Wm. McK. Stone.

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known, England.

12 MAIDEN NAME OF MOTHER: Susan ?. ?.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known, England.

14 Informant: Mrs. May M. Stone (wife)
(Address) #1705 N. Broadway.

15 Filed MAR 26 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 23, 1920, to Mar 23, 1921, that I last saw him alive on Mar 22, 1921, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. M. Beltzhoover, M. D.

, 19 (Address) 817 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Mar-26-21

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Burial Permit Clerk.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D. 52291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52291

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Katie Sinclair

(Residence in Baltimore: No. 2534 E. Baltimore St.; 69 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	W	Single

6-DATE OF BIRTH, Oct. (Month) 5 (Day), 1831. (Year)

7-AGE, 69 yrs. 5 mos. 19 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): F

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Perry Sinclair

11-BIRTHPLACE OF FATHER (State or Country), Talbot Co Maryland

12-MAIDEN NAME OF MOTHER Mary Amelia Sherwood

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline A. Sinclair

(Address) 2534 E. Balto. St.

15-

Filed ..... Robert P. Harrison, Registrar.

MAR 26 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3-24- March 24, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-22-1921, to 3-24-1921, that I saw h.er alive on March 24 1921, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 2½ ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Nathan J. Handaw M. D.

3-24-, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cem.	March 28, 1921.

20-UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52292 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52292

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 N. Patterson Park Ave ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Albert Metz

(a) RESIDENCE. No. 1414 N. Patterson Pk ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Decorator

(b) General nature of industry, business, or establishment in which employed (or employer) Window Decorator

(c) Name of employer The Hub

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John J Metz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Kober

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr John J Metz
(Address) 1414 N Patterson Park Ave

15 Filed MAR 26 1921 Robert P. Harris, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1921

17 I HEREBY CERTIFY, That I attended deceased from October 26 1918, to March 24 1921, that I last saw h[illegible] alive on March 24 1921, and that death occurred, on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D P Berg M.D. M. D.

March 26 1921 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 26 1921
20 UNDERTAKER	**ADDRESS**
Henry Hoerth & Son	1301 E Eager St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state name of INFORMANT should be carefully supplied. AGE should be stated at it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.52293 [illegible] 498

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52293

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 4417 Alabama Ave ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Tobeason

(Residence in Baltimore: No. 4417 Alabama ave St.; ....yrs., 1 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ~~March~~ Feb 7, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Theodore Tobeason

11-BIRTHPLACE OF FATHER (State or Country). Norway

12-MAIDEN NAME OF MOTHER Virginia Nelson

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theodore Tobeason

(Address) 4417 Alabama ave

15-

Filed ....., 1921. Robert P. Harrison, Registrar.

MAR 26 1921

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 24 1921, to March 25 1921, that I saw h[illegible] alive on March 24 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Colitis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Colitis

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. S. Tibbett M. D.

March 25, 1921. (Address) 2220 Garrison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, March 26, 1921

20-UNDERTAKER Jos Joerdens + Son

ADDRESS 217 S. Paca st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52294

CERTIFICATE OF DEATH.

81

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N. Charles ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James, Cardinal Gibbons.

(a) RESIDENCE. No. 408 N. Charles ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Arch-Bishop of 018

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

Permission granted
J. Frederick Hemsley, M.D.
Asst. Com. of Health.

Permission requested to keep remains until Thursday, March 31, 1921.

Henry W. Mears & Son

Registrar

MAR 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1921.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8. 1920, to March 24, 1921,

that I last saw h in alive on March 24, 1921,

and that death occurred, on the date stated above, at 11 55 a. m.

The CAUSE OF DEATH* was as follows:

Asthenia - Sclerosis (Cerebral)

Arteriosclerosis

Hydrothorax (duration) ....yrs. 5 mos. ....ds.

CONTRIBUTORY (Secondary) Old age

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Medical Clinical & Symptoms

(Signed) Charles O'Donovan, M. D.

March 25, 1921 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cript	3/31 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS on back of certificates. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52295 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52295

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 N Charles ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Holmes Whiteley

(a) RESIDENCE. No. 1008 N Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed~~, or ~~divorced~~
HUSBAND of
(or) ~~WIFE~~ of Mary Ludlow Whiteley

6 DATE OF BIRTH (month, day, and year) May 21 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	72	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coffee Broker

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Wm S. Whiteley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Eliza R Holmes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Florida

14 Informant Mary L Whiteley
(Address) 1008 N Charles St

15 Filed MAR 26 1921 Robert P. Harrison, Registrar
Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20th 1920, to March 20th 1921, that I last saw him alive on March 24th 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis,
(involving Coronary Arteries)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm F. Lockwood, M. D.

19 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	March 28 1921
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Sons Co	Ensor and Collaby

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.52296 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52296

82

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 E. Chase ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Rogers Edwards

(Residence in Baltimore: No. 2015 E. Chase St. St.; 5 yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 7, 1868
(Month) (Day) (Year)

7-AGE, 52 yrs. 8 mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk 069
(b) General nature of industry, business, or establishment in which employed (or employer): Post Office Dept.

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, John Edwards

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Ann Rogers

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Phillips H. Edwards

(Address) 451 E. 22nd St. Baltimore

15- MAR 26 1921 Robert F. Harrison, ..., 191.....
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1919, to March 25 1921, that I saw her alive on March 25 1921, and that death occurred, on the date stated above, at 10.30 p m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolus

(Duration) yrs. mos. ds.

(Signed) Chas. Reid Edwards M. D.

March 25 1921. (Address) 33 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, March 28, 1921.

20-UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-3-19—H. P. Co.—1000 Bks.

D.52297 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52297

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Smith

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) Hospital Records, New City Hospital

15 Filed 1921 Robert F. Harrison, Registrar

MAR 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 23, 1921

that I last saw him alive on March 23, 1921

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross Sputum exam.

(Signed) R Sherman, M. D.

3-26 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL MAR 26 1921 19

20 UNDERTAKER Commissioner Health, ADDRESS

Per. Wm. E. WOODALL

E should be stated EXACTLY. PHYSICIAN should state
at it may be properly classified. Exact statement of OCCUPA-
s on back of certificates.
mation should be carefully supplied. AGE sh
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

D.52298 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52298

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1516 Thames Street ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Kwasniewski

(Residence in Baltimore: No. 1516 Thames Street St.; 37 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, UNKNOWN (Month) / (Day) / (Year)

7-AGE, 96 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, UNKNOWN

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER UNKNOWN

13-BIRTHPLACE OF MOTHER (State or Country), POLAND

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M.F.Sadowski

(Address) 705 S. Ann Street.

15- Robert P. Harrison, ..., 191.....

AR 267921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 26 1921, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

3/27, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus Cem.	Mar 29th, 1921
20-UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann St.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state carefully all information which may be important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.52299 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH S. Balto. Gen. Hosp. REGISTERED NO. 77

CITY OF BALTIMORE: (No. ..... ST.: 23 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida Schaefer.

(a) RESIDENCE. NO. 1200 Light St. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Oliver Schaefer

6 DATE OF BIRTH (month, day, and year): Dec. 25, 1894

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
26	3	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Piano Player
(b) General nature of industry, business, or establishment in which employed (or employer): Saloon Manager
(c) Name of employer: Future Parlor

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Samuel B. Ridgware

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Harriet Quail

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Agnes V. Legge
(Address): 1200 Light St.

15 Filed ....., 19 ..... Registrar

R-26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24 1921

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1921, to March 24, 1921, that I last saw her alive on March 24, 1921, and that death occurred, on the date stated above, at 8:20 P m.

The CAUSE OF DEATH* was as follows:

Fibrinus pericarditis,

(duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary): Myocardial insufficiency

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? 1200 Light St.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Study of heart

(Signed) L. C. Dobihal, M. D.

, 19 (Address) S. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Mar 28 1921
20 UNDERTAKER	ADDRESS
F. C. Krauss & Son	539 Fawcett

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20.52300 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.52300

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Robt Garrett Hosp

CITY OF BALTIMORE: (No. 27 N Carey ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Francis Jones

(a) RESIDENCE. No. 318 N Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 13 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert M. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gladys B. Whitcraft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Camden New Jersey

14 Informant Robert B. Jones

(Address) Robert P. Harrison,

Filed MAR 26 1921, 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1921

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1921, to March 24, 1921, that I last saw h in alive on March 24, 1921, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy Exam

(Signed) L. H. W. Clift, M. D.

3/25, 1921 (Address) 27 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity-Cemetery	Mar 26 1921
20 UNDERTAKER W. W. Shriver	ADDRESS 1018 Edmondson ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52301 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Linden Ave & Lake Drive

CITY OF BALTIMORE: (No. Riviera Apt ST.: 13 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Rosenbaum

(a) RESIDENCE. No. Lake Drive ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Rosenbaum

6 DATE OF BIRTH (month, day, and year): May 21st 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Millinery

(b) General nature of industry, business, or establishment in which employed (or employer): Buyer

(c) Name of employer: do

9 BIRTHPLACE (city or town) (State or country): Boston Mass

PARENTS

10 NAME OF FATHER: Herman Rosenbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Upshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Mrs Aaron Rosenbaum Riviera Apt

15 Filed ....., 19.... Robert P. Harris.., Registrar

AR261921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to March 24th, 1921, that I last saw h— alive on March 24, 1921, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Angina pectoris —

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lantz, M. D.

3/25, 1921 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	March 27 1921

20 UNDERTAKER: Ward & Goodman ADDRESS 1118 N Royal

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement should state TION is very important. See instructions on back of certificates. OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52302 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D.52302

CERTIFICATE OF DEATH.

79v

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Bank ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorinzo Cappellino alias Hatter

(a) RESIDENCE. No. 1403 Bank ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Cappellino alias Hatter

6 DATE OF BIRTH (month, day, and year) January 15 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) John Hatter 1403 Bank

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

R26 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1921, to March 23, 1921.

That I last saw him alive on March 23, 1921,

and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. Palmisano, M. D.

, 19 (Address) 7 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 28 1921
20 UNDERTAKER	ADDRESS
Wendell Dilfel & Son	378 Penn.

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D.52303 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52303

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 505 Ogston St.

CITY OF BALTIMORE: (No. 505 Ogston St. Ward 17) REGISTERED No. C 79

2-FULL NAME Frances Ann Sheppard

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 505 Ogston St

St.: 56 yrs., 10 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April 28 (Month) (Day) 1860 (Year)

7-AGE, 76 yrs. 10 mos. 24 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Annarundel Co.

PARENTS.

10-NAME OF FATHER, Charles Brooks

11-BIRTHPLACE OF FATHER (State or Country), Annarundel Co.

12-MAIDEN NAME OF MOTHER Eliza Matthews

13-BIRTHPLACE OF MOTHER (State or Country), Annarundel Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances A. Hall

(Address) 509 Claggett St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 24th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 18th, 1921, to March 24th, 1921, that I saw her alive on March 22nd, 1921, and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Sclerosis Aortic Insufficiency of the Heart

(Duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) Immediate mos. ds.

(Signed) Harry Kleibel M. D.

March 25th, 1921 (Address) 1224 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn Cemetery | DATE OF BURIAL, March 28 1921

20-UNDERTAKER Edward H. Pye | ADDRESS 903 Edmonson Ave Catonsville Md

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 52304 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52304

CERTIFICATE OF DEATH.

15 × 28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1614 Pressman ST.: 15 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Alton

(Residence in Baltimore: No. 1614 Pressman St.: yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	colored	Single

6-DATE OF BIRTH, July (Month) 12 (Day), 1918 (Year)

7-AGE, 2 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Anne Arundel Co. Md.

PARENTS.

10-NAME OF FATHER, Willis Starks

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Leonia Alton

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Alton

(Address) 1614 Pressman St

15- MAR 26 1921 Robert P. Harrison, ..., 191..... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) jury find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. A. T. Hennessy M. D. (Coroner.)

March 25 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Annapolis Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Mar 26 1921
20-UNDERTAKER Edward Angyal	ADDRESS 1463 N Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

at the dispensary at Baker's
Cove. Ans, as Annie Starks.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework.* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.52305 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D.52305

CERTIFICATE OF DEATH.

285

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 114 S Addison Al ST.) 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Brooks

(a) RESIDENCE. NO. 114 S. Addison Al ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Brooks

6 DATE OF BIRTH (month, day, and year) Dec 9, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel S. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Coy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Mary Brooks

(Address) 114 S. Addison Al

15 Filed MAR 26 1921 Robert P. Harrison, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1921, to March 25, 1921, that I last saw him alive on March 24, 1921, and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

3/25, 1921 (Signed) M. A. O'neill M. D.

(Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar 28 '21
20 UNDERTAKER	ADDRESS
Geo. L. Schnabel & Bro	201 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52306 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52306

CERTIFICATE OF DEATH. 9-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 S Durham St.; 2 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Byers.

(a) RESIDENCE. No. 507 S. Durham St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Byers.

11 BIRTHPLACE OF FATHER (city or town) Milwaukee (State or country) Wisconsin

12 MAIDEN NAME OF MOTHER Julia Keyes.

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Frank Byers (Address) 507 S. Durham St

15 [illegible] Robert P. Harrison, Registrar

MAR 26 1921

[illegible] Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to March 26, 1921, that I last saw h— alive on March 26, 1921, and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(over)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Throat culture.

(Signed) Chas. S. Nenstadt. M. D.

. 19 (Address) 221 S. B'way.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 26 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

52307 HEALTH DEPARTMENT—CITY OF BALTIMORE 52307

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. [illegible] ST.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Snyder

(Residence in Baltimore: No. 22 N. Pearl St.) St. (2 yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Sgl

6-DATE OF BIRTH, Apr (Month) 14 (Day), 1916 (Year)

7-AGE, 5 yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER Jacob Snyder

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Granville Snyder

(Address) Ingrote Penna

15-

FILED MAR 27 1921 191.... ROBERT J. KRAUTER Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mch (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
History of accidentally striking the head
6 days. (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Epilepsy
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)
Mar 27, 1921 (Address) 1659 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Ingrote Penna	Mar 27, 1921
20-UNDERTAKER	ADDRESS
Wm A Staley	Fulton & Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

52308 HEALTH DEPARTMENT—CITY OF BALTIMORE 52308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH USPHSHosp#56, Fort McHenry, REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore, Md. ST.: 24 WARD) 35 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Puckett

(a) RESIDENCE. No. U.S.P.H.S. Hosp. #56, Fort McHenry, Md. WARD. 35
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer --------

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER James F. Puckett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T. Rainbolt Registrar
(Address) U.S.P.H.S. Hosp. #56, Fort McHenry, Md.

15 Filed MAR 27 1921 ROBERT J. KRAUSE Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1921, to March 26, 1921, that I last saw him alive on March 26, 1921, and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary, active

(duration unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis, Orchitis Bi lateral

(duration unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)

, 19 (Address) USPHSHosp. #56, Fort McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet N.C.	Mar 26, 1921
20 UNDERTAKER	ADDRESS
S. Levinson & Bro	1127 E Balto St

952309 HEALTH DEPARTMENT—CITY OF BALTIMORE 952309

CERTIFICATE OF DEATH.

167

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Allen

(Residence in Baltimore: No. 1712 Ramsey St

St.(yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH. unknown, 1
(Month) (Day) (Year)

7-AGE. 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laundry 088

9-BIRTHPLACE. (State or Country), Virginia

PARENTS.

10-NAME OF FATHER. Joseph Allen

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Matilda Wyatt

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Allen

(Address) Middlesex Co. Va.

15- Filed MAR 27 1921 ROBERT J. KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
1st Burns over legs & lower abdomen, His Clothes caught fire while lighting oil stove accidental (Duration)..... yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Acute Nephritis
..... (Duration)..... yrs. mos. 2 ds.

(Signed) James M Fenton M. D.
(Coroner.)
Mar 26 1921. (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs. mos. 4 ds. In the State..... yrs. mos. ds.
Where was disease contracted, if not at place of death?.....
1712 Ramsey St
Former or usual residence 1712 Ramsey St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Middlesex Va.	March 28 1921
20-UNDERTAKER Geo J Smith	ADDRESS 1808 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Salavitch

D52310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52310

30

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Salavitch

(a) RESIDENCE. NO. 25-7 S. Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 23/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry Salavitch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lillian Zelmanz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records (Address) Mercy Hosp.

15 MAR 27 1921 [illegible] Registrar

Burial Permit Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26 1921

17

I HEREBY CERTIFY, That I attended deceased from 3/23, 1921, to 3/26, 1921, that I last saw h— alive on 3/24, 1921, and that death occurred, on the date stated above, at 6.25 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 1X ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 5hrs ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis A. Ridgely, M. D.

3/27, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Rosedale	3-27- 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D5-2311 HEALTH DEPARTMENT—CITY OF BALTIMORE D52311

CERTIFICATE OF DEATH.

REGISTERED NO. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3011 Brighton ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Harrison Rhine

(a) RESIDENCE. No. 3011 Brighton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Florence Rhine

6 DATE OF BIRTH (month, day, and year) July 7, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Correspondent

(b) General nature of industry, business, or establishment in which employed (or employer) Express Co

(c) Name of employer American Ry Exp Co

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Luther P Rhine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Carrie A Morrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Florence Rhine
(Address) 3011 Brighton St

15 FILED MAR 27 1921 ROBERT A BAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1921

17

I HEREBY CERTIFY, That I attended deceased from September, 1917, to March 24, 1921, that I last saw him alive on March 24, 1921, and that death occurred, on the date stated above, at 8. 0. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 4 yrs. — mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) H. D. Bruton, M. D.

3/25, 1921 (Address) 301 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Mch 25 1921
20 UNDERTAKER E. Schlosman & Son	ADDRESS 1334 Hanover

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

952312

HEALTH DEPARTMENT—CITY OF BALTIMORE

952312

CERTIFICATE OF DEATH. January 6 1921

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 4508 Grindell Lane ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Annie Voigt

(Residence in Baltimore: No. 4508 Grindell Lane St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, April 22, 1840
(Month) (Day) (Year)

7-AGE, 80 yrs. 11 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housemary
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Marcus

(Address) 4508 Arlington Ave

15- Filed MAR 27 1921, 19.... ROBERT A LAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to March 25 1921, that I saw her alive on March 24 1921, and that death occurred, on the date stated above, at 7.25 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) One yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. H. Marcus M. D.

March 25 1921 (Address) 3100 Harford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, March 28, 1921.

20-UNDERTAKER E Schumacher

ADDRESS 1034 Hanover st

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52313

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40 N. Bentalow ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emilia Schrenker

(a) RESIDENCE. NO. 40 N. Bentalow ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Schrenker

6 DATE OF BIRTH (month, day, and year) Apl. 21st 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Carl Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johnnan Jacob

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Matthew Doetsch.

(Address) 2724 Eiglo Ave

15 Filed MAR 27 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to March 25, 1921, that I last saw h— alive on March 25, 1921, and that death occurred, on the date stated above, at 4.35 P. m.

The CAUSE OF DEATH* was as follows:

Angina. Pectoris.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edw. O Kuhlman, M. D.

3/26. 1921 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 28 1921
20 UNDERTAKER	ADDRESS
Henry Hoerth Son	1301 E Lafayette

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52314

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE. (No. 2044 Gough ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Casmer Kamienski

(a) RESIDENCE. No. 2044 Gough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
		10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Antoni Kamienski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Tekla Zyck

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Tekla Kamienski
(Address) 2044 Gough

15 Filed MAR 27 1921. SOPHIA KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/24/21, 19..., to 3/25/21, 19..., that I last saw h[illegible] alive on 3/24/21, 19..., and that death occurred, on the date stated above, at 845 A.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) H. D. Herrmann, M. D.

3/26/21 (Address) 2919 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 28 1921
20 UNDERTAKER	ADDRESS
John H Weber	1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52315 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D52315

CERTIFICATE OF DEATH. 1092

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1517 Mc Elderry ST.; 7 WARD)

2-FULL NAME Wealyana Maddox

(a) RESIDENCE. NO. 1517 Mc Elderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Maddox

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Somerset Co. Md

PARENTS

10 NAME OF FATHER Stephen Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co. Md

12 MAIDEN NAME OF MOTHER Loretta Sudler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) same Md

14 Informant Levin Maddox (Address) 1517 Mc Elderry St

15 Filed MAR 27 1921 ROBERT I. LYNCH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/17, 1921, to 3/23, 1921, that I last saw her alive on 3/23, 1921, and that death occurred, on the date stated above, at 6:50 P m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastric Catarrh

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. O'Donovan, M. D.

3/24/21 (Address) 1522 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Mar 27 1921

20 UNDERTAKER R B Gross ADDRESS 1405 McElderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52316

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 160 W. Hamburg ST.: 23 WARD)

2-FULL NAME Joseph Edw Booth

(a) RESIDENCE: NO. 160 W Hamburg ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Gen'l

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Booth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Commodore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Thos Booth
(Address) 160 W Hamburg St

15 FILED MAR 27 1921 ROBERT A KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/1921

17 I HEREBY CERTIFY, That I attended deceased from 3/20/21, to 3/26/21, that I last saw him alive on 3/26/21, and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
"Pulmonary Tuberculosis"
Jno Bowley M.D.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Complication
Active (duration about 8 days) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No Signed

What test confirmed diagnosis?

(Signed) Jno Bowley, M. D.

3/26 1921 (Address) 926 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mch 28 1921
20 UNDERTAKER	ADDRESS
John H Toadvine	1412 Hull St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D52317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52317

CERTIFICATE OF DEATH.

REGISTERED NO. C 80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 S. Broadway ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Golaner.

(Residence in Baltimore: No. 619 S. Broadway St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April 14 (Month) (Day), 1842 (Year)

7-AGE, 78 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Jacob Rosenberg

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Nellie Rosenberg

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon Rosenstein

(Address) 619 S. Broadway

15- MAR 27 1921 Filed, 191. Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 4 1921, to March 25 1921, that I saw h[illegible] alive on March 25 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Pelvis

(Duration) yrs. 3 mos. ds.

(Signed) Herman J. Deming M. D.

Mar 26 1921. (Address) 1600 East Lexington Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, March 27, 1921

20-UNDERTAKER J. Ahrens & Co — ADDRESS 1611 Madison

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52318

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 282

CITY OF BALTIMORE: (No. 1442 Ward St ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia Morlock

(a) RESIDENCE. No. 1442 Ward ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Morlock

6 DATE OF BIRTH (month, day, and year) May - 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Eddie Butts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Va

12 MAIDEN NAME OF MOTHER Callie Butts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va

14 Informant Mrs Morlock
(Address) 1442 Ward St

15 Filed MAR 27 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1921, to March 24, 1921, that I last saw her alive on March 22, 1921, and that death occurred, on the date stated above, at 6.45a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Gustav Fohlmann, M. D.

, 19 (Address) 606 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	March 27 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Utica

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D52319

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Druid Hill Ave ST. 14 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Phillips

(a) RESIDENCE. No. 1622 Druid Hill Ave ST. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, ~~Married, Widowed~~ or ~~Divorced~~ (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1851 ~~Feb~~

7 AGE 70 Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Brown (Address) 1622 Druid Hill ave

15 MAR 27 1921 ROBERT E KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 25, 1921, that I last saw h~~e~~ alive on March 25, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward J. Wheatley, M. D.

3/26 1921 (Address) 1230 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Cemetery Relay Md — DATE OF BURIAL: March 27 1921

20 UNDERTAKER: John H Toadvine — ADDRESS: 142 N Hill St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

952320 HEALTH DEPARTMENT—CITY OF BALTIMORE 952320

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 254 N. Arlington Av. St.; 18 WARD) REGISTERED No. C 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Taylor

(Residence in Baltimore: No. 254 Arlington Av. St.; 41 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March (Month) 23 (Day) 1880 (Year)

7-AGE, 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer) Print Finished

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Albert Taylor

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lucy Shepherd

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Taylor

(Address) 254 Arlington Av.

15- Filed MAR 27 1921, 191.. ROBERT J. KRAUTER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 17- 1921, to Mar. 23 1921, that I saw h.e alive on Mar. 22- 1921, and that death occurred, on the date stated above, at 1-55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-pneumonia
Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. C. McCulloch M. D.

Mar. 24, 1921 (Address) 906 N. Stricker St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Olivet Cem. DATE OF BURIAL, Mar 24., 1921

20-UNDERTAKER Bowers & Freeland ADDRESS 114 W. Lexington St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D52321

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 302 N Fremont Ave ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward McKenny

(Residence in Baltimore: No. 302 N Fremont Ave St.; ..... yrs., 6 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, ~~MARRIED~~, WIDOWED, OR ~~DIVORCED~~, (Write the word.) Single

6-DATE OF BIRTH, ... 1919
Oct (Month) 22 (Day) (Year)

7-AGE, 1 yrs. 6 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or estsblishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Lancaster S Carolina

PARENTS.

10-NAME OF FATHER, Henry McKenny

11-BIRTHPLACE OF FATHER (State or Country), S C

12-MAIDEN NAME OF MOTHER Annie Marrison

13-BIRTHPLACE OF MOTHER (State or Country), S C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward McKenny

(Address) 302 N Fremont Ave

15- Filed MAR 27 1921 191.... ROBERT J. LAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 26, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 25 1921, to March 26 1921, that I saw h[illegible] alive on March 25 1921, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) P H Casey M. D.

3-26, 1921. (Address) 300 N Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Lancaster S. C.

19-PLACE OF BURIAL OR REMOVAL, Lancaster S. Carolina — DATE OF BURIAL, March 27, 1921

20-UNDERTAKER Mrs Charles B Jones — ADDRESS 211 N Pine St

important. See instructions on back of certificate.

D52322 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52322

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 117 W. West St. ST.: 23 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Jefferies. (C)

(Residence in Baltimore: No. 117 W. West St. St.; 6 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, Do not know, (Month) / (Day), 1 (Year)

7-AGE, 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer. gd
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), live in Balt 7 Years South Carolina.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Jones. (C)

(Address) 117 W. West St.

15- Filed MAR 27 1921, 191 ROBERT J. CRAUTH Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 23rd. 1921. (Month) (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M Eenwardt M. D. (Coroner.)

March 24 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	March 27 to 21
20-UNDERTAKER Mrs B A Elliott	ADDRESS 1725 Ashland Av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2052323 HEALTH DEPARTMENT—CITY OF BALTIMORE 2052323

CERTIFICATE OF DEATH.

REGISTERED No. C 25 579

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 9th St. & 3rd. Ave. Fairfield ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie Lash. (C)

(Residence in Baltimore: No. 9th St. & 3rd. Ave. Fairfield. St.: 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH, January 1st. 1896. (Month) (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
25 yrs. 2 mos. 24 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Lie in Baltmore 3 months North Carolina.

PARENTS.

10-NAME OF FATHER, William Taylor. (C)

11-BIRTHPLACE OF FATHER (State or Country), North Carolina.

12-MAIDEN NAME OF MOTHER Martha McCleary. (C)

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Moore. (C) mother.

(Address) 9th. St. & 3rd. Ave. Fairfield.

15-MAR 27 1921 ROBERT J. KRAUTER

Filed ..... 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25th. 1921. (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Elliott Reinhardt (Coroner) M. D.

March 25 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence North Carolina

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery — DATE OF BURIAL, March 27. 1921

20-UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D52324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 749 Ryan St.; 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Booth

(Residence in Baltimore: No. 749 Ryan St St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Unknown (Month) (Day) (Year)

7-AGE. 63 about yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER. Elijah Booth

11-BIRTHPLACE OF FATHER (State or Country). Calvert Co. Md

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country). Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Beatty

(Address) 749 Ryan St

15 MAR 27 1921 ROBERT J. KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 25th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb-12 1921, to Mch. 24 1921, that I saw him alive on Mch 23 1921, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Cirrhosis

(Duration) yrs. 1 mos. ds.

(Signed) C. L. Ruckold M. D.

Mch 25, 1921 (Address) 130 S. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cemetery

DATE OF BURIAL. 3/27, 1921

20-UNDERTAKER Jos. Scott Hooper

ADDRESS 406 W. Conway St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052325 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 052325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland. General Hospital. ST.: 9 WARD) 120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret. Kenney.

(a) RESIDENCE. No. 1102 E. North Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 28, 1896

7 AGE 25 Years 1 Months 25 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. Government

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Patrick H. Kenney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary E. Woods.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Jennie Ing

(Address) 1106 East North avenue

15 MAR 27 1921 ROBERT J. KEATOR Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to March 25, 1921, that I last saw her alive on March 25, 1921, and that death occurred, on the date stated above, at 12.15 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Chas Wilbur Stewart. M. D.

3/25. 1921 (Address) Md. Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: March 28 1921

20 UNDERTAKER: McGinnis & Carroll, — ADDRESS: 4203 Ridgewood ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

952326 HEALTH DEPARTMENT—CITY OF BALTIMORE 952326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 North Chapel ST.; 6 WARD) REGISTERED NO. 679

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Ellen Ebberts.

(a) RESIDENCE. No. 10 North Chapel ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. 5 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Ebberts

6 DATE OF BIRTH (month, day, and year): Oct 3, 1860

7 AGE: 60 Years 5 Months 22 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Buckeystown Frederick Co

PARENTS

10 NAME OF FATHER: Whitmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Jacob Ebbert Jr. 10 North Chapel St

15 Filed MAR 27 1921 ROBERT S. TRAUTE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25, 1921

17

I HEREBY CERTIFY, That I attended deceased from October 25, 1920, to March 25, 1921, that I last saw her alive on March 25, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Aortic Insufficiency

(duration) 1 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) - yrs. - mos. 1 ds.

18 Where was disease contracted if not at place of death? * * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Lingwood, M. D.

3/26 1921 (Address) 5 N. Washington Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — DATE OF BURIAL: Mar. 24 1921

20 UNDERTAKER: Louis Heemann — ADDRESS: 32 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

52327 HEALTH DEPARTMENT—CITY OF BALTIMORE 52327

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 E 20th St.: 9 Ward) 170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida C Casson

(a) RESIDENCE. No. 509 E 20th St., 9th Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Robert Casson

6 DATE OF BIRTH (month, day, and year) Dec 25th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co Md

PARENTS

10 NAME OF FATHER Samuel Getty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co. Md.

12 MAIDEN NAME OF MOTHER Margaret Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co Md

14 Informant Robert Casson

(Address) 509 E 20th St

15 MAR 27 1921 ROBERT J. KRAUTER Registrar

Buried ... Clock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1921

17

I HEREBY CERTIFY, That I attended deceased from March 10 - 1921, to March 25th, 1921,

that I last saw her alive on March 24th, 1921,

and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uraemia - Coma.

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Bronchitis - Pellagra by general Erysipelatous infection (duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Symptoms - Examination

(Signed) Frederic U. Beetler, M. D.

3 25, 1921 (Address) 26 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 27th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052328

HEALTH DEPARTMENT—CITY OF BALTIMORE

052328

55

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1628 E Monument ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Regenia McGahan

(a) RESIDENCE. No. 1628 E Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 6th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER David F. McGahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Fannie Rutledge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bermuda

14 Informant Chas. Jay Gahan

(Address) 1628 E Monument St

15 MAR 27 1921 NOTARY PUBLIC Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 19 21

I HEREBY CERTIFY, That I attended deceased from Mar 20 21, to Mar 25 21, that I last saw h[illegible] alive on Mar 24 21, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH was as follows:

Colitis;

Fatty Infiltration Cardiac

(duration) 3 yrs mos ds

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs 5 mos ds

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Slade, M. D.

(Address) 1437 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	3/28/ 1921

20 UNDERTAKER J. G. Moran

ADDRESS 3001 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

952329 HEALTH DEPARTMENT—CITY OF BALTIMORE 952329

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 34 E Barney ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Steinbock

(a) RESIDENCE. No. 34 E Barney ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene Steinbock

6 DATE OF BIRTH (month, day, and year) 2/7-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Die Setter

(b) General nature of industry, business, or establishment in which employed (or employer) Die

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm. Steinbock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lena Huth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Steinbock (Address) 34 E Barney

15 MAR 27 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1921, to Mar 26, 1921, that I last saw ~~him~~ alive on Mar 25, 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Rheumatism Chronic

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical.

(Signed) J. Lee Hamm, M. D.

3/27/1921 (Address) 19 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	3/29 1921
20 UNDERTAKER	ADDRESS
I. Frew McCully	130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052330 HEALTH DEPARTMENT—CITY OF BALTIMORE 052330

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 134 W West St. 23 WARD)

2-FULL NAME Infant Hackett

(a) RESIDENCE: (Usual place of abode) No. 134 W West St., WARD.

Length of residence in city or town where death occurred yrs. mos. 4 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/26/21

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or ..... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Hockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Bessie Hunt

(Address) 134 W West St

15 Filed MAR 27 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/26, 1921, to 3/26, 1921, that I last saw h... alive on 3/26, 1921, and that death occurred, on the date stated above, at 11.10 a m.

The CAUSE OF DEATH* was as follows:

Premature Labor.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Antenatal

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. Hall Bowley, M. D.

3/26, 1921 (Address) 1908 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Monday 1921
20 UNDERTAKER P. J. Parham	ADDRESS 647 W Lee St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52331

CERTIFICATE OF DEATH.

102

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1340 S. Charles ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislawa Redik

(a) RESIDENCE. No. 1429 S. Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Thomas Redzik

6 DATE OF BIRTH (month, day, and year) April 25-1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Ignacy Kaiczek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Oleszczuk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Ignacy Redik
(Address) 1429 Hanover St

15 MAR 27 1921 ROBERT A. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1921

17 I HEREBY CERTIFY, That I attended deceased from March 4th, 1921, to 25th, 1921, that I last saw h.. alive on 25th, 1921, and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Abscess of Stomach

Pyloric Stenosis, (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 16th.

Was there an autopsy? no

What test confirmed diagnosis? Tumor Pyloric Stenosis

(Signed) Harry [illegible], M. D.

, 1921 (Address) 1508 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	March 28 1921
20 UNDERTAKER	ADDRESS
William Falkowski	1618 Eastern Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052332 HEALTH DEPARTMENT—CITY OF BALTIMORE 252332

CERTIFICATE OF DEATH.

REGISTERED NO. 9104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Walsh

(a) RESIDENCE. No. 1517 E. Preston St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 13 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	5	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Walsh

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Brunner 3/27/21

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Margaret Walsh
(Address) 1517 E Preston St

15 Filed MAR 27 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to March 26, 1921, that I last saw him alive on March 26, 1921 and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Positive culture

(Signed) B Walsh M. D.

(Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	3/27/21
20 UNDERTAKER	ADDRESS
Robt F Turner Inc	1442 Broadway

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

952333

HEALTH DEPARTMENT—CITY OF BALTIMORE

952333

CERTIFICATE OF DEATH

REGISTERED NO. 45

1-PLACE OF DEATH Howard A. Kelly Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.; 3 WARD)

2-FULL NAME Mrs. Rachael Dallinger

(a) RESIDENCE. No. 1429 E. Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married.

5a If married, widowed, or divorced (or) WIFE of M Dallinger

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	44.	3	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lebo, Germany.

PARENTS

10 NAME OF FATHER Julius Victor Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Lea Livingston.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Mr M. Dallinger.
(Address) 1429 E. Balto St.

15 Filed MAR 27 1921 [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1920, to Mar. 27, 1921, that I last saw h[illegible] alive on Mar. 27, 1921, and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows:

Malignant hypernephroma Left Kidney

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Peritoneal sarcoma.

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Mar. 24, 1921.

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic exam. tissue

(Signed) Arthur C. Primrose, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	March 27 1921
20 UNDERTAKER	ADDRESS
Levering	1127 E Balto St

IMPORTANT—Before this certificate is filled out, see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1903 Parkwood ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Christopher Hull

(a) RESIDENCE. No. 1903 Parkwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes K. Hull

6 DATE OF BIRTH (month, day, and year) April 8 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Milady Blouse

(c) Name of employer Roger & Gross

9 BIRTHPLACE (city or town) (State or country) Martinsburg W Va

PARENTS

10 NAME OF FATHER Christopher Hull

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va

12 MAIDEN NAME OF MOTHER Alice Carmack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Agnes K Hull

(Address) 1903 Parkwood

15 Filed MAR 27 1921 ROBERT I. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1921, to March 25, 1921, that I last saw him alive on March 25, 1921, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gray, M. D.

3/26, 1921 (Address) 677 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Martinsburg W Va	March 28 1921

20 UNDERTAKER L. A. Schmidt & Son ADDRESS Norman

L A Filero

CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52335 — HEALTH DEPARTMENT--CITY OF BALTIMORE — D 52335

CERTIFICATE OF DEATH

84

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1051 N. Durham St.: 7 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilbur McClarren

(Residence in Baltimore: No. 1051 N. Durham St.; 4 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: 17 October (Month) (Day), 1920 (Year)

7-AGE: ..... yrs. 5 mos. 26 ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Albert McClarren

11-BIRTHPLACE OF FATHER (State or country): N. Carolina

12-MAIDEN NAME OF MOTHER: dont Know

13-BIRTHPLACE OF MOTHER (State or country): N Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert McClarren
(Address) 1051 N. Durham St

15. Filed MAR 27 1921 19... ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March 26 (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 26 1921, that I saw him alive on March 2, 1921, and that death occurred, on the date stated above, at 9.7 p m.
The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ..... yrs. ..... mos. 16 ds

Contributory (SECONDARY) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas J Summers M. D.
March 27, 1921 (Address) 1025 N Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Salem Cem.
DATE OF BURIAL: March 27th 1921

20-UNDERTAKER: Harry A Vodery
ADDRESS: 1725 Orleans St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52336 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52336

CERTIFICATE OF DEATH. 105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rear 532 Mosher St. 14 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia J Lansinger

(a) RESIDENCE. No. Rear 532 Mosher St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colute	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 14 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Emmetsburg (State or country) Md

PARENTS

10 NAME OF FATHER Wm Tyson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Theresa Vaughan

13 BIRTHPLACE OF MOTHER (city or town) Emmetsburg (State or country) Md

14 Informant Rosa F Lansinger (Address) Rear 532 Mosher St

15 Filed MAR 28 1921 ROBERT I KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Mch 4 - 1921, to Mch 26 - 1921, that I last saw her alive on Mch 25 - 1921, and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal Infection

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Infirmities of old age -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hm. home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis General Examination

(Signed) Samuel A Bair M. D.

19 (Address) 937 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmetsburg Md	Mch 28 1921
20 UNDERTAKER	ADDRESS
Wm Fahey & Sons	827 N North Ave

TION is very important. See instructions on back of certificates. may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

052337

HEALTH DEPARTMENT—CITY OF BALTIMORE

052337

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No.) 1406 Lanvale St.; 15 (Ward)

REGISTERED NO. 370

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Taylor

(a) RESIDENCE. No. 1406 Lanvale St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Taylor

6 DATE OF BIRTH (month, day, and year) — 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
37	1884			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Maryland

PARENTS

10 NAME OF FATHER Peter Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lee Grimmering

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Sampson
(Address) 2004 Hunter St

15 FILED MAR 28 1921 ROBERT F. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25- 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 23, 1921, to March 25, 1921, that I last saw h.e.r alive on 3-25, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Suppurative Ulcer of Epiglotis and Tonsellitis Suppulatave

2 wks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exposure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R Boykin, M. D.

. 19 (Address) 1380 n Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL Mar. 28 1921

20 UNDERTAKER Joseph A Farrell ADDRESS 2309 Pa Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Important. See instructions on back of certificate. Statement of OCCUPATION is very

52338 HEALTH DEPARTMENT—CITY OF BALTIMORE 52338

CERTIFICATE OF DEATH.

REGISTERED NO. C 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 East 32nd ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Sophia Carroll

(Residence in Baltimore: No. 707 E. 32nd St.; ....yrs., 5 mos. ....ds.)

In Balto. Lifetime.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. December 25, 1844 (Month) (Day) (Year)

7-AGE. 76 yrs. 3 mos. ....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None (At Home)
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER. John K. Carroll

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER Sophia Bonn

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. D. Thweatt

(Address) 707 E. 32nd St.

15- Filed MAR 28 1921, 191... ROBERT J. BAUER Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1 1921, to March 20 1921, that I saw her alive on March 25 1921, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Senility

Chronic Myocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. R. Davis M. D.

....., 1921 (Address) 2108 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, 3-28-, 1921

20-UNDERTAKER Henry W. Jenkins & Co. ADDRESS Orchard & McCulloh

D52339 Luebbuesen

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52339

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST.: 1675 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth K. Luebbuesen

(Residence in Baltimore: No. 1623 Ashburton St.) about 40 yrs. (St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, don't know
(Month) (Day) (Year)

7-AGE, about 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Krueger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Rohe

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Ludick

(Address) 1623 1623 Ashburton

15- Filed MAR 28 1921 191... ROBERT A KRAUTER Registr. Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) Investigation find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemmorhage + Shock
Street Car Accident
which ran over + Crushed
Lt. Leg (Duration) ..... yrs. ..... mos. 1/4 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H. Perkins M. D.
(Coroner.)
Mar. 25, 1921 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. 1/4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....
Northeast + Ashburton St.

Former or usual residence 1623 Ashburton

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem, Md. DATE OF BURIAL, Mar. 28 1921

20-UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52340 HEALTH DEPARTMENT—CITY OF BALTIMORE D52340

CERTIFICATE OF DEATH. 812

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 612 Lamont Ave. (St.) 9 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret C. Dolland

(a) RESIDENCE. NO. 16½ Lamont Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ds. How long in U. S., if of foreign birth? 60 yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lee Dolland.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas Dolland

(Address) 16½ Lamont. ave

15 Filed MAR 28 1921 ROBERT S. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/21

I HEREBY CERTIFY, That I attended deceased from Mar 20, 1921 to Mar 25, 1921.

that I last saw h[illegible] alive on Mar 24, 1921,

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Asthenia-Senescis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) G. C. Hyde, M. D.

3/25, 1921 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	March 28 21

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford ave.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52341

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52341

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2707 W. North Ave. ST.: 15 79 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Alice Zollinger

(a) RESIDENCE. No. 2707 W. North Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Zollinger

6 DATE OF BIRTH (month, day, and year) Nov. 3" 1850

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John J. Wise

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maria Keeley

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Virginia

14 Informant Lillian E. Zollinger (Address) 2707 W. North Ave.

15 Filed MAR 28 1921 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25" 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4 1921, to March. 25 1921, that I last saw h.. alive on March. 24 1921, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) C. M. Livingston, M. D.

March 26 1921 (Address) 826 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Mar. 28 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N Bolton St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52342

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52342

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 S. Gilmor ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen R. Lowman

(a) RESIDENCE. NO. 132 S. Gilmor ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Ofbl

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Ira Lowman

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Healy

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Ira Lowman
(Address) 132 S Gilmor St

15 Filed MAR 28 1921 ROBERT F KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to March 26, 1921, that I last saw h— alive on March 25, 1921, and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cuneiformsis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) Edward Nicholas, M. D.

, 19 (Address) 24 W Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	March 28 1921.
20 UNDERTAKER James Dignan & Son	ADDRESS 1000 S. Paca St

CAUSE OF DEATH should state plainly in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

952343 HEALTH DEPARTMENT—CITY OF BALTIMORE 952343

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Myrtle ave ST. 17 WARD)

2-FULL NAME Lillian M Dashields

(a) RESIDENCE. No. 1215 Myrtle ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divgreed (write the word)
Female	Colored	Single

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Prince Georges co Md

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm S. Dashields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Fannie Dashields
(Address) 1215 Myrtle ave

15 Filed MAR 28 1921 ROBERT A LAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1921, to March 25, 1921, that I last saw h[illegible] alive on March 25, 1921, and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) As Thrum

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? 1215 Myrtle ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) A. M. Fiore, M. D.

March 26 1921 (Address) 712 S Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	March 1921
20 UNDERTAKER	ADDRESS
L L Brown & Son	1087 W Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52344

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52344

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Neal

(a) RESIDENCE. No. 838 S. Eutaw st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER James Stafford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Kate Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records
(Address) W.T.H.

15 MAR 28 1921 [illegible] Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1920, to March 26, 1921, that I last saw him alive on March 25, 1921, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. J. Rigney, M. D.

3-26-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct.	May 29 1921

20 UNDERTAKER: Isaiah S. Brown, Son — ADDRESS 1018 W. Monty

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

252345 HEALTH DEPARTMENT—CITY OF BALTIMORE 252345

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. William Dawson 25 ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fairfield Md

(a) RESIDENCE. No. 3rd ave & 15th street ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Perry Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Howard Dawson
(Address) 2020 W Monument st

15 Filed MAR 28 1921, 19.... ROBERT J. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/16 '21, 19...., to 3/25 '21, 19....,
that I last saw him alive on 3/24 '21, 19....,
and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) unknown

(no history) " (duration) " yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? clinical

3/26 '21 (Signed) J. Gus Bowley, M. D.
(Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	March 28 1921
20 UNDERTAKER	**ADDRESS**
H. P. Broom & Son	1016 W. Monte

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52346

1921 D 065-52346

CERTIFICATE OF DEATH.

30

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: Pl WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Davis

(a) RESIDENCE. NO. 929 Park Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dec 12 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1 year	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 0/0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James L Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bessie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Johns Hopkins Hospital Records

15 FILED MAR 28 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to March 26, 1921, that I last saw her alive on March 26, 1921, and that death occurred, on the date stated above, at 2 35 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Necropsy findings

(Signed) W D Dayton, M. D.

3.27, 1921 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Mar, 28 1921

20 UNDERTAKER Samuel Newby

ADDRESS 1921 N Gilmor

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

052347

HEALTH DEPARTMENT—CITY OF BALTIMORE

052347

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3706 Clifton Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos F Smith

(Residence in Baltimore: No. 3706 Clifton Ave St.; 50 yrs., ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH. May 2, 1852 (Month) (Day) (Year)

7-AGE. 68 yrs. 10 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired Stn. Mstr.

9-BIRTHPLACE, (State or Country), New York State

PARENTS.

10-NAME OF FATHER, Thomas Smith

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Margret Mahoney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F Smyth

(Address) Bradford Pa.

15-

Filed MAR 28 1921, 191.....

ROBERT E KRAUTER Registrar.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 25th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 23d 1921, to March 25 1921, that I saw him alive on March 25 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)....yrs....mos. 2 ds.

CONTRIBUTORY (Secondary) None discernable

(Duration)....yrs....mos....ds.

(Signed) Chas E Parker M. D.

3/25, 1921. (Address) 3123 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. ? mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? — — — — —

Former or usual residence — — — — — —

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. — DATE OF BURIAL. March 28, 1921

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52348

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D52348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 Barclay ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie M. Katz

(a) RESIDENCE. NO. 1812 Barclay ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Katz

6 DATE OF BIRTH (month, day, and year) April 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Smithfield Va

PARENTS

10 NAME OF FATHER Wm Leathers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Orange Co Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thomas Katz

(Address) 1812 Barclay St

15 Filed MAR 28 1921 ROBERT F. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to March 27, 1921, that I last saw her alive on March 26, 1921, and that death occurred, on the date stated above, at 1.10 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Torry, M. D.

, 19 (Address) 4142 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Mar. 29 1921
20 UNDERTAKER George J Smith	ADDRESS 1000 N Fayett. St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52349

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4002 Massachusetts Ave St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Johanna Cloney

(a) RESIDENCE. No. 4002 Massachusetts Ave St. 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John Wood Cloney

6 DATE OF BIRTH (month, day, and year) Dec 19, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 237

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER David Wm Rasknopf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Schuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John E. Cloney (Address) 4002 Massachusetts Ave

15 Filed MAR 28 1921 ROBERT P. LAZZATI Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1920, 19..., to March 26, 1921, that I last saw h alive on March 24, 1921, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

..... (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harold Plummer, M. D.

. 19 (Address) Catonsville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Mar 29 1921
20 UNDERTAKER George J Smith	ADDRESS 1000 N Payette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D52350 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 52350

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 N. Caralin ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Ward

(a) RESIDENCE. No. 305 N. Caralin ST., WARD.
(Usual place of abode) (If nonresident give rity or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Ward

6 DATE OF BIRTH (month, day, and year) unknown 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 37

(b) General nature of Industry, business, or establishment in whirh employed (or employer)

(r) Name of employer

9 BIRTHPLACE (rity or town)
(State or rountry) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Md
(State or rountry) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or rountry)

14 Informant Angie Meade
(Address) 309 N. Caralin st

15 FILED MAR 28 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar. 21, 1921, to Mar. 25, 1921, that I last saw h 22 alive on Mar 25, 1921, and that death occurred, on the date stated above, at 11-30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contrarted if not at plare of death?

Did an operation prerede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt L Green M. D.

3-26. 1921 (Address) 120½ Aisquith st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homiridal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury cmetry	Mar 28th 1921
20 UNDERTAKER	ADDRESS 741
J Leon Hall	Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52351

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52351

48

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 815 N. Howard St.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Groto

(a) RESIDENCE. No. 815 N. Howard ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. — mos. — ds. How long in U. S., if of foreign birth? 64 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E. Groto

6 DATE OF BIRTH (month, day, and year) March 5, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which ~~employed~~ (or employer) 014

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John R. Groto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Bunkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo W Little

(Address) 2700 Edmondson Av

15 Filed MAR 23 1921 19 ROBERT E KRAUTH Registrar

Postal Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 22, 1921, to March 25, 1921, that I last saw him alive on March 25, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Infirmities of age.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 15 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Howard C. Silver, M. D.

19 (Address) 3766 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
Baltimore	March 28 1921

20 UNDERTAKER Geo. W. Little

ADDRESS 2700 Edmondson ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D52352 HEALTH DEPARTMENT—CITY OF BALTIMORE D52352

CERTIFICATE OF DEATH.

REGISTERED No. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1328 Pennsylvania St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert H. White Sr.

(Residence in Baltimore: No. 1328 Pennsylvania St.; 85 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Widower

6-DATE OF BIRTH, Jan (Month) 2 (Day) 1836 (Year)

7-AGE,	If LESS than 1 day,
85 yrs. 2 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sheet metal worker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Harry White

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert H. White

(Address) 1328 Pennsa Av

15-

Filed MAR 28 1921 ROBERT J. KRAUTH Registrar.

Daniel Powell Deputy

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 26 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 11 1921, to Mar 26 1921, that I saw h in alive on Mar 26 1921, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial enlarged Prostate & Edema

(Duration) yrs. several mos. ds.

(Signed) H. E. Krantz M. D.

Mar 26, 1921. (Address) 1102 N Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorraine	Mar 29 1921

20-UNDERTAKER	ADDRESS
Geo W Little	2100 Edmondson Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Stack

D52353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52353

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 N. Arlington Ave St. 18 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia C. Stack.

(a) RESIDENCE. NO. 538 N. Arlington Ave ST. ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, ~~Married, Widowed,~~ or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 21-1921

7 AGE Years: — Months: 1 Days: 6 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Howard N. Stack.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rochester N.Y.

12 MAIDEN NAME OF MOTHER Emma Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) V. T. Stack 538 N Arlington Ave

15 Filed MAR 28 1921 ROBERT F. BRAUTIGAM Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/21

17

I HEREBY CERTIFY, That I attended deceased from 2/21/21, 19..... to 3/27/21, 19....., that I last saw her alive on 3/27/21, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Malnutrition.

(duration) yrs. mos. 34 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. C. Hunt, M. D.

3/27/21, 19 (Address) 19 W Mont C

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem DATE OF BURIAL: Mar 28 1921

20 UNDERTAKER: Bertram Hyde ADDRESS: 1723 Lafayette Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052354

HEALTH DEPARTMENT—CITY OF BALTIMORE

052354

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1956 Patterson Place ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman H. Piercy

(a) RESIDENCE. No. 1956 Patterson Place ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced (write the word)~~: Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Schwarz.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John J. Piercy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Alma Linton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va

14 Informant: John J. Piercy
(Address) 1956 Patterson Place

15 Filed MAR 28 1921 ROBERT J. CLAUDE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1921

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to March 26, 1921, that I last saw him alive on 3/26/1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. A. Braun, M. D.

3/27/1921 (Address) 2600 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 28 1921
20 UNDERTAKER	ADDRESS
Jas C. Miller	2334 Jefferson St

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D52355 HEALTH DEPARTMENT—CITY OF BALTIMORE D52355

43

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 E. 41th ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth G. Foard

(Residence in Baltimore: No. 613 E 41th St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	W	Married

6-DATE OF BIRTH, Feb (Month) 1 (Day), 1871 (Year)

7-AGE,	If LESS than 1 day,
50 yrs. 1 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Co.

PARENTS.

10-NAME OF FATHER, Benjamin Foard

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Hannah McFadden

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert L. Foard

(Address) 613 East 41st st

15- Filed MAR 28 1921 191.....

ROBERT E KRAUTER

Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 27 1920, to March 27 1921, that I saw h—m alive on March 27 1921, and that death occurred, on the date stated above, at 7 15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Mammae
(Bilateral)

(Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secoudary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John L. Finch M. D.

3/27, 1921. (Address) 3522 Greenmount Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Druid Ridge	March 29, 1921

20-UNDERTAKER	ADDRESS
Pirkler & Pirkler	1739 Eager

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D52356 Stratemeyer D52356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 26 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rudolph Stratemeyer

(Residence in Baltimore: No. 1104 Seaton St Highlandtown 60 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Widowed

6-DATE OF BIRTH, ... January 1 ....., 1845
(Month) (Day) (Year)

7-AGE, 76 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Day Labourer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Hanover, Germany

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country). Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret M. Resch

(Address) 1104 S. Second St.

15-MAR 28 1921 ROBERT J. KRAUTER
Filed ....., 191... Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 1921, to March 27 1921, that I saw h[illegible] alive on March 27 1921, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

~~Duodenal ulcers~~ Decubitus ulcers

Pulmonary Edema

(Duration) ... yrs. 11 mos. 2 ds.

CONTRIBUTORY (Secondary) ~~Pulmonary Edema~~ Decubitus ulcers

(Duration) ... yrs. 2 mos. 2 ds.

(Signed) Louis Faehs M. D.

March 27, 1921. (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel Cemetery	March 30, 1921
20-UNDERTAKER	**ADDRESS**
Sikler + Sikler	1739 E. Eager St.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D52357 HEALTH DEPARTMENT—CITY OF BALTIMORE D52357

CERTIFICATE OF DEATH.

REGISTERED No. C 14 81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Park ave - St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda P Sanders -

(Residence in Baltimore: No. Lifetime St.; — yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	Widow

6-DATE OF BIRTH, Oct (Month) 28 (Day), 1845 (Year)

7-AGE, 76 yrs. 4 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm E Hooper

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Catharine Bell

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis A Gazenby

(Address) Clarks Lane & Park Heights Ave

15- Filed MAR 28 1921, 191.... ROBERT S KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 26 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20 1916, to March 26 1921, that I saw her alive on March 26 1921, and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart dilatation

(Duration) 5 yrs. mos. ds.

(Signed) John D King M. D.

March 26, 1921 (Address) 1425 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemy — DATE OF BURIAL, Mch 28, 1921

20-UNDERTAKER J D Mitchell — ADDRESS 1201 W Fayette St.

Important. See instructions on back of certificate.

K

Spec. 4-9-19—H. P. Co.—1000 Bks.

D52358

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52358

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1334 N. Fulton Ave ST.; 15 WARD)

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Clarke

(a) RESIDENCE. No. 1334 N Fulton Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas L Clarke

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Wm McKenna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Loftus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas L Clarke (Address) 1334 N Fulton Ave

15 Filed MAR 28 1921 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1921, to March 25, 1921, that I last saw h alive on March 25, 1921, and that death occurred, on the date stated above, at 4,0 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Bruno Jones, M. D.

19 (Address) 1402 E. Rosalyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	March 29 1921

20 UNDERTAKER Martin Baker & Sons ADDRESS

(Rev. 6-9-19—H. P. Co.—1000 Rks.

D52359 HEALTH DEPARTMENT—CITY OF BALTIMORE D52359

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1827 N Monroe ST. 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Koll

(a) RESIDENCE. No 1827 N Monroe ST., 15 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Koll

6 DATE OF BIRTH (month, day, and year)

7 AGE: 59 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Hettig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eva Hettig

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: P. K. Boetinger

(Address) 2900 Hillsdale st

15 MAR 28 1921 ROBERT A KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar[illegible] 1, 1921, to Mar. 26, 1921, that I last saw her alive on Mar. 26, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Hepatitis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Metzel M. D.

March 27, 1921 (Address) 190 3 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mar 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 N North Ave

IT may be properly classified. Exact statement of OCCUPA
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52360

CERTIFICATE OF DEATH.

REGISTERED NO. 4491

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1430 Andre ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen K Shade

(a) RESIDENCE. NO. 1430 Andre ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Hand

(b) General nature of industry, business, or establishment in which employed (or employer) Co.

(c) Name of employer National Biscuit

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Shade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jennie Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) John Shade 1430 Andre St

15 MAR 28 1921 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 17, 1921, to Mar. 25, 1921, that I last saw h 21 alive on Mar. 24, 1921, and that death occurred, on the date stated above, at 6. P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

8 ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm. T. Seabury, M. D.

3/26 1921 (Address) 638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	March 28 1921
20 UNDERTAKER	ADDRESS
Chas. E. Evans & Sons	1428 Shade

TION is very important. See instructions on back of ... be properly classified. Exact statement of OCCUPA- ... ck of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-52361 D-52361

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Woman's Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaretta Pleasants Bonsal Lanahan

(Residence in Baltimore: No. Potts Spring Road Balto Co St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, June (Month) 2 (Day), 1891 (Year)

7-AGE, 29 yrs. 8 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Leigh Bonsal

11-BIRTHPLACE OF FATHER (State or Country), Norfolk Va

12-MAIDEN NAME OF MOTHER, Mary C. Pleasants

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leigh Bonsal

(Address) 18 E. Mt Vernon Pl Balto

15- Filed MAR 28 1921 [illegible] CLERK

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 16 1921, to March 26 1921, that I saw her alive on March 26 1921, and that death occurred, on the date stated above, at 11 5-7 p m.

The CAUSE OF DEATH* was as follows:

Concussion of the Brain
from accidental fall from
a horse

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY none
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) E E Duncan M. D.

March 26, 1921 (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 10 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Timonium Balto Co. Md.

19-PLACE OF BURIAL OR REMOVAL, GREEN MOUNT CEMETERY CO.

DATE OF BURIAL, 3-29-, 1921

UNDERTAKER HENRY W. JENKINS & SONS CO.

ADDRESS MC CULLOH & ORCHARD STS.

Important. See instructions on back of certificate. If occupation is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-52362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-52362

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Alfred Fisher

(a) RESIDENCE. NO. Ruxton Md. ST., WARD. Ruxton Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 10 ds. How long in U. S., if of foreign birth? Mr yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Alfred Fisher

6 DATE OF BIRTH (month, day, and year) June 3 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work U.S. Fidelity & Trust Co.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Mr. Frank Fisher

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Miss. Jennie Poore.

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Charles Fisher
(Address) Ruxton Md.

15 MAR 28 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921.

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1921, to Mar 27, 1921, that I last saw h. alive on Mar 27, 1921, and that death occurred, on the date stated above, at 12 45 p m.

The CAUSE OF DEATH* was as follows:

Visceral Carcinomatosis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar 3-21

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation & Autopsy

(Signed) H. D. Sammenbaum M. D.

3/27 1921 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL GREEN MOUNT CEMETERY CO. DATE OF BURIAL 3-29 1921

20 UNDERTAKER HENRY W. JENKINS & SONS CO. ADDRESS MC CULLOH & ORCHARD STS.

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

First organ involved unknown.

Mar. 31 16

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-52363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-52363

1-PLACE OF DEATH

REGISTERED No. 91

CITY OF BALTIMORE: (No. 1214 Laurens St. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Kraemer

(a) RESIDENCE. No. 1214 Laurens ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo P. Kraemer

6 DATE OF BIRTH (month, day, and year) Nov 17 - 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J F Kraemer (Address) Woodlawn

15 MAR 28 1921 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/21 19

17 I HEREBY CERTIFY, That I attended deceased from 3/23/21, 19 21, to 3/26/21, 19, that I last saw h[illegible] alive on 3/26/21, 19, and that death occurred, on the date stated above, at 12-05 am.

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

Sudden (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. C. Hauck, M. D.

(Address) 1433 W Mort

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Mar 29 1921
20 UNDERTAKER	ADDRESS
J Hering & Co	2008 Aliceanna

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2052364

HEALTH DEPARTMENT—CITY OF BALTIMORE

2052364

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1341 Calhoun ST.: 15 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winfield Johnson

(a) RESIDENCE. No. 1341 N Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
22	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Abey Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Abey Jenkins
(Address) 1341 N Calhoun St

15 Filed MAR 28 1921, 19 ROBERT A. TRAUTH Registrar
Burial Permit Oliver

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sat 3/26/1921

17 I HEREBY CERTIFY, That I attended deceased from 3-20-, 1921, to 3-26-, 1921, that I last saw him alive on 3-25-, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Gastritis and Mitral Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W P Boykin, M. D.

, 19 (Address) 1348 N Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 28 1921
20 UNDERTAKER	ADDRESS
JAMES H. DENNIS	1303 PRESTMAN ST.

TION is very important. See instructions on back of certificates.

D52365 HEALTH DEPARTMENT—CITY OF BALTIMORE D52365

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Opposite Southern Hotel or on way home a, Hospital ST.: 16 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sam Clark

(Residence in Baltimore: No. 1037 N. Carey St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Sgle

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (Tradesman?)
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Warden

(Address) 1118 Woodyear St

15- Filed MAR 28 1921, 191.... ROBERT J. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart disease ? Asthma ? Bronchitis ?

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) W. S. Culbert (Coroner.) .....M. D.

Mch 27 1921 (Address) 1624 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, March 27 1921

20-UNDERTAKER JAMES H. DENNIS | ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-62366

CERTIFICATE OF DEATH.

D-52366

REGISTERED NO. 792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 N. Rose ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Metzger

(a) RESIDENCE. No. 704 N. Rose ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelius Metzger

6 DATE OF BIRTH (month, day, and year) July 8 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Schilling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Cornelius Metzger
(Address) 704 N. Rose St

15 MAR 28 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 23, 1921, to March 25, 1921, that I last saw h 4 alive on March 26, 1921, and that death occurred, on the date stated above, at 1430 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None necessary

(Signed) Stanislaus McCleary, M. D.

, 19 (Address) 1609 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem U A Co	March 29 1921
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son,	811 N Howard

Burial Permit Clerk

Funeral Directors & Embalmers.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-52367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-52367

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 Sinclair Lane ST.; 8 WARD)

2-FULL NAME Helen M Clark

(a) RESIDENCE. No. 2123 Sinclair Lane ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Clark

6 DATE OF BIRTH (month, day, and year) Dec. 31 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Md

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jos Beacham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Loraine

12 MAIDEN NAME OF MOTHER Mary Athey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Laraine

14 Informant Harry Clark

(Address) 2123 Sinclair Lane

15 FILED MAR 28 1921 ROBERT J. BRADER Registrar

Burial Permit Oleat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26th 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 25 1921 to Mar. 26 1921, that I last saw her alive on Mar. 26 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Rumbold M. D.

3-27 1921 (Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Mar 29 1921
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son,	811 N Howard

Funeral Directors & Embalmers.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D52368 Jacobs D52368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90-010

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 Monroe St.; 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Jacobs

(Residence in Baltimore: No. 2317 Monroe St.; 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) 1871 (Year), 1 (Day)

7-AGE, 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), born in Balt. City Balto. City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Miller

(Address) 1424 E. Biddle St.

15- MAR 28 1921 Filed ..... 191.... ROBERT B. CRAWFORD Registrar. (Clerk) Sophia Pope

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 20th 1921, to March 25th 1921, that I saw h.... alive on March 24th 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) .... yrs. .... mos. 3 ds.

CONTRIBUTORY (Secondary) Tuberculosis Pulmonary

..... (Duration) .... yrs. .... mos. 10 ds.

(Signed) R. C. Ellis M. D.

3/26/1921 (Address) 92 W. Mosher

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem — DATE OF BURIAL, March 28, 1921

20-UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052369

HEALTH DEPARTMENT—CITY OF BALTIMORE

052369

CERTIFICATE OF DEATH.

5 - 99

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Johnson

(a) RESIDENCE. No. 214 Eden St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ada Johnson

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Live in Balt 23 years

9 BIRTHPLACE (city or town) (State or country) Cockeysville, Maryland

PARENTS

10 NAME OF FATHER J. Henry Diggs

11 BIRTHPLACE OF FATHER (city or town) Townson, (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Adams

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital

15 MAR 28 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1921

17

I HEREBY CERTIFY, That I attended deceased from February 5, 1921, to March 25, 1921, that I last saw h.im alive on March 25, 1921, and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Vegetative Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 2-5-21

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Holden, M. D.

3-26-1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 28 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Av

TION is very important. See instructions on back of certificates.

D52370 HEALTH DEPARTMENT—CITY OF BALTIMORE D52370

CERTIFICATE OF DEATH. 175-003 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp' St.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Day

(Residence in Baltimore: No. same St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col	Married

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 42 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country) Lives in NC Lives in Balt'o for over

PARENTS.

10-NAME OF FATHER, A Day

11-BIRTHPLACE OF FATHER (State or Country) N. C.

12-MAIDEN NAME OF MOTHER Dannie Merris

13-BIRTHPLACE OF MOTHER (State or Country) N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jr. Day

(Address) Jr. N. C.

15- Filed MAR 28 1921, 191.... ROBERT J. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mch 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion brain Thrown
Caused by a fall from Va. R.R.
train near Bowie Md.
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY accidental
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
Mch 28, 1921 (Address) 163 Ry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Oxford N.C.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Clifford NC	March 28 1921

20-UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D52371

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Baetz.

(a) RESIDENCE. No. 531 S 3rd St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			5 wks	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Baetz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Fechley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed MAR 28 1921 19.. ROBERT J. [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to March 27, 1921, that I last saw her alive on March 27, 1921, and that death occurred, on the date stated above, at 1 Am. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Dawson, M. D.

3-27 1921 (Address) J H H Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL March 28 1921

20 UNDERTAKER Lilly Ed Zeile ADDRESS 403 S. Wolfe St.

FILL IN WITH PEN AND INK. Read instructions on back of certificates. Type is very important. See instructions on back.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Premature Birth.

D52372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52372

CERTIFICATE OF DEATH.

REGISTERED No. C 137

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Hubert.

(Residence in Baltimore: No. 1911 Gough St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, May (Month) 15 (Day), 1903 (Year)

7-AGE, 17 yrs. 10 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Typist.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, William E. Hubert.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Bertha Depro

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Hubert.

(Address) 1911 Gough St.

15- Filed MAR 28 1921 191.... ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Wm. Gardner M. D.
(Coroner)

3-28-1921 (Address) 1911 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel Cem.	March 29 1921
20-UNDERTAKER Lilly and Zitler.	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52373

CERTIFICATE OF DEATH.

53

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 451 Eastern Ave 2d WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Bantz

(a) RESIDENCE. NO. 451 Eastern Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School boy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph J. Bantz

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Augusta Wiso

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph J. Bantz (Address) 451 Eastern Ave

15 Filed MAR 28 1921 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26. 1921

17 I HEREBY CERTIFY, That I attended deceased from January, 1921, (to) March 24, 1921, that I last saw h[illegible] alive on March 26, 1921, and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Pleuroleukaemia

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. J. Marx M. D.

March 28, 1921 (Address) 827 N. Rutland St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	March 29 1921

20 UNDERTAKER Lilly & Zieler ADDRESS

THIS CERTIFICATE should be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

52374

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52374 HEALTH DEPARTMENT—CITY OF BALTIMORE D52374

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3412 Mt. Pleasant Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis M. Benson

(a) RESIDENCE. No. 3412 Mt. Pleasant Ave ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Benson

6 DATE OF BIRTH (month, day, and year) March 18-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Obrecht Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William A. Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lina Droney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary V. Benson

(Address) 3412 Mt. Pleasant Ave.

15 MAR 28 1921

ROBERT F. KRAUTER Registrar

Burial Perm't Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/15, 191..., to 3/27, 1921, that I last saw him alive on 3-26, 1921, and that death occurred, on the date stated above, at 9.34 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

immediate (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Int. Nephr.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. J. Krauss M. D.

3/28, 1921 (Address) 719 34 m^c Elderry Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	March 30 1921
20 UNDERTAKER	ADDRESS
Lilly Ed Zeiler	1038 N. Howard St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

052375 HEALTH DEPARTMENT—CITY OF BALTIMORE 052375

CERTIFICATE OF DEATH.

REGISTERED NO. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph's Hosp. ST.; 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanisława Dekowska

(a) RESIDENCE. NO. 3242 East Ave ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Manuel

6 DATE OF BIRTH (month, day, and year) Mar 18-1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36			7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER J. Lewandowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Joseph Dekowski
(Address) 3242 East Ave

15 MAR 28 1921 ROBERT A. RESNICK Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to March 25, 1921, that I last saw her alive March 25, 1921, and that death occurred, on the date stated above, at 10:10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronsnas, M. D.

3-25-1921 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Mar 29 1921
20 UNDERTAKER	ADDRESS
Stephen J. Piatkowski	1005 S. Kenwood Ave

TION is very important. See instructions on back of certificates.

D52376 HEALTH DEPARTMENT—CITY OF BALTIMORE D52376

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 475-885 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salvatori Renaldi

(Residence in Baltimore: No. 7 N. Pearl St.: (yrs. 20 mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 24, 1862 (Month) (Day) (Year)

7-AGE, 58 yrs. 9 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Fruit Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Gen

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonora Renaudo

(Address) 7 Pearl St

15- Filed MAR 28 1921, 191.. ROBERT J. BRUTON Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 26, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral fracture Skull - accidentally Struck by Motor Truck Driven by Unknown Negro (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured Thigh (Duration) yrs. mos. ds.

(Signed) W. S. Haley M. D. (Coroner.)

March 27 1921 (Address) 16 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Bethel Cemetery

DATE OF BURIAL, March 29, 1921.

20-UNDERTAKER H. M. Routson

ADDRESS 230 Green St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52377

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 579

CITY OF BALTIMORE: (No. New City Hospital ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Hook

(a) RESIDENCE. No. Fairfield, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Nathan Iish

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Dearie Eavenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed MAR 28 1921 ROBERT F. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1921, to March 26, 1921, that I last saw her alive on March 25, 1921, and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No especial test

(Signed) B Herman, M. D.

3-26-21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch	Mch 29 1921
20 UNDERTAKER	ADDRESS
Isaiah L. Brown	1084 W Monty

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52378 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52378

CERTIFICATE OF DEATH

1-PLACE OF DEATH U.S.P.H.S. #56 REGISTERED NO.....

CITY OF BALTIMORE: (No. 1" " " ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sulo Naski

(a) RESIDENCE. NO. U.S.P.H.S. #56 ST., Ft. McHenry Md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 Hours 2/28/21 to 3/28/21 How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 30 | Months | Days | If LESS than 1 day.... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer): " 080

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Finland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Record

15 Filed MAR 28 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 28 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/8/21, 19..., to 3/27/21, 19...

that I last saw him alive on 3/27/21, 19...

and that death occurred, on the date stated above, at 11.0 Pm m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Thomas R. Payne, M. D.

(Address) Ft. McHenry, SURGEON, U. S. P. H. S.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: Mar 29 1921

20 UNDERTAKER: S. Levinson & Bro — ADDRESS 1127 E Balto st

TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Blks.

D.52379 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52379

CERTIFICATE OF DEATH.

REGISTERED No. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 University Parkway ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur V. Milholland

(Residence in Baltimore: No. 219 University Parkway St.; 77 yrs., 11 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 26, 1843 (Month) (Day) (Year)

7-AGE, 77 yrs. 11 mos. 0 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Arthur Milholland

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen --------

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. X. Molholland

(Address) 219 University Parkway

15-

R281921 Robert F. Hart[illegible] Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 26, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1921, to March 26 1921, that I saw him alive on March 26 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 4 yrs. mos. ds.

(Signed) H. L. Holcomb M. D.

....., 191... (Address) 728 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 3/29, 1921

20-UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52380 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D. 52380

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 717 So. Bouldin ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY NELKA,

(a) RESIDENCE. No. 717 So. Bouldin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 41 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White	Widow,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Nelka,

6 DATE OF BIRTH (month, day, and year) March 25-1847.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at home,

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER John Kawakowski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary Sadowska,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Rosie Biggsman. Daughter.
(Address) # 717 So. Bouldin Street

15 Filed Robert P. Harri... Registrar

AR 28 1921 Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 1, 1921, to Mch 26, 1921, that I last saw h.. alive on March 24, 1921, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Wanless, M. D.

March 28, 1921 (Address) #24 Bouldin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Mar 30 1921.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Wholey)

D. 52381 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52381

CERTIFICATE OF DEATH.

10-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 E Cross ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry D. Wholey

(a) RESIDENCE. NO. 119 E Cross ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Dry Dock

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry D. Wholey Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary J. Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant H D Wholey

(Address) 119 E Cross St.

15 [illegible] 19 Robert P. Harrison, Registrar

MAR 28 1921

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to March 20, 1921, that I last saw h[illegible] alive on March 20, 1921, and that death occurred, on the date stated above, at 11.00 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. M. Nelson, M. D.

Mar. 28. 1921 (Address) 1279 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3/29 1921
20 UNDERTAKER	ADDRESS
J. Talley & Sons	318 Light St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- that it may be properly classified. Exact statements on plain terms, so

Spec.—6-9-19—H. P. Co.—1000 Bks.

Please call for Remains

2,52382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2,52382

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 887 Hollins ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Devlin

(a) RESIDENCE. NO. 881 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
(12 Hours)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Christopher Devlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosetta Cavanaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address)

15 Filed ..., 19... Registrar

R 2 8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/26/, 1921, to 3/27/, 1921,

that I last saw h— alive on 3/27/21, 19...,

and that death occurred, on the date stated above, at 5-A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Bernard J. Feeney, M. D.

3/27, 1921 (Address) 910 N Luther

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19...

20 UNDERTAKER

ADDRESS

MAR 28

Commissioner Health.

TION is very important. See instructions on back of certificates. ... may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D.52383 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52383

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 N. Stricker ST.; 19 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME No name — Shaw

(Residence in Baltimore: No. 322 N. Stricker St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	White	Sing'l.

6-DATE OF BIRTH, March 26, 1921.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos....ds.	....hrs. or about 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Harry F. Shaw.

11-BIRTHPLACE OF FATHER (State or Country), Frederick, Md.

12-MAIDEN NAME OF MOTHER Leona K Davis

13-BIRTHPLACE OF MOTHER (State or Country), Frederick, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry F. Shaw.

(Address) 322 N Stricker St

15- MAR 28 1921 Robert P. Harrison, Registrar.

Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 26, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 26 1921, to March 26 1921, that I saw h[illegible] alive on [illegible] 1921, and that death occurred, on the date stated above, at about 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

about 5 lbs Month,

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) M Burns and Reed M. D.

March 26, 1921. (Address) 1 E Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER

ADDRESS

MAR 28 [illegible]

Transcriber Notes

Spec.—8-24-14—M. & T.—2000 Bks.

D.52383 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52383

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 N. Stricker ST.; 19 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME No name — Shaw

(Residence in Baltimore: No. 322 N. Stricker St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	White	Sing'l.

6-DATE OF BIRTH, March 26, 1921.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos....ds.	....hrs. or about 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Harry F. Shaw.

11-BIRTHPLACE OF FATHER (State or Country), Frederick, Md.

12-MAIDEN NAME OF MOTHER Leona K Davis

13-BIRTHPLACE OF MOTHER (State or Country), Frederick, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry F. Shaw.

(Address) 322 N Stricker St

15- MAR 28 1921 Robert P. Harrison, Registrar.

Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 26, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 26 1921, to March 26 1921, that I saw h[illegible] alive on [illegible] 1921, and that death occurred, on the date stated above, at about 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

about 5 lbs Month,

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) M Burns and Reed M. D.

March 26, 1921. (Address) 1 E Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER

ADDRESS

MAR 28 [illegible]

Important. See instructions on back of certificate.

D. 52384 HEALTH DEPARTMENT--CITY OF BALTIMORE D. 52384

80

CERTIFICATE OF DEATH

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 724 E 33rd St. WARD 9)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Wm Gregory

(Residence in Baltimore: No. 724 E. 33rd St. St.: 1 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Aug 13 (Month), 13 (Day), 1872 (Year)

7 AGE: 48 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Ship Builder
(b) General nature of industry, business, or establishment in which employed (or employer): Ship Yard

9 BIRTHPLACE (State or country): Charlestown W. Va.

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (State or country): Don't Know

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (State or country): Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nilda Gregory

(Address) 724 E 33rd St

15. Mar 28, 1921

Robert F. Harrison, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 27 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1921, to, Mar. 27, 1921, that I saw him alive on Mar. 27, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Heart Block

(Duration) ..... yrs. ..... mos. 1 1/2 ds

Contributory (SECONDARY) Angina Pectoris

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed), H. E. Prentiss M. D.

Mar. 28, 1921 (Address) 634 Gramercy Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Philadelphia — DATE OF BURIAL: Mar 29, 1921

20 UNDERTAKER: Robt Schneider Inc — ADDRESS: 1424 W Baltimore

MAR 28 1921

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 52385 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52385

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 905 N. 40th St. ST.: 13 76 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Heims (30 yrs., 8 mos. 3 ds.)

(Residence in Baltimore: No. 905 N. 40th St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 23 (Day), 1890 (Year)

7-AGE, 30 yrs. 8 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER John Heims

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary E. Grace

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Laura May Heims

(Address) 905 N. 40th St.

15-

Filed....., 191.... Robert P. Harrison, Registrar.

R 28 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
Dorsal Spine Fracture
(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)
(Duration) .....yrs.....mos.....ds.

(Signed) John Grossmann M. D.
(Coroner.)

March 28 1921 (Address) 1632 Rolandene

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Mary's (Hampden) DATE OF BURIAL, March 29 1921

20-UNDERTAKER Horace Burgee & Son ADDRESS 363 Falls Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.52386 (Mail) D.52386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST. 13 WARD) REGISTERED No. C

2-FULL NAME Ray Paul

(Residence in Baltimore: No. 606 N. North - St.? 4 yrs., 4 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Sgl

6-DATE OF BIRTH, ... (Month), 1 (Day) (Year)

7-AGE, 6 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, N. Paul

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Marie Spindler

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Paul

(Address) Lyth. Pa

15- Robert P. Harrison, Registrar.

Mch. ....., 191.....

3 28 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Fract. Spine
accidentally struck by
auto (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (Duration) yrs. mos. ds.

(Signed) H. Finley M. D.
(Coroner.)

Mch 28, 1921 (Address) 1657 Ruy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Geo. Smith — DATE OF BURIAL, 1000 A. Apr 30, 19....

20-UNDERTAKER York Penna — ADDRESS Mar. 30/21

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D52387 (Daulerio) D.52387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lombard Near Parkin ST.) 1075-004 (WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicholas Daulerio

(Residence in Baltimore: No. 1126 Proctor St.) 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Dont Know (Month), 1 (Day), ... (Year)

7-AGE,	If LESS than 1 day,
32 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Daulerio

(Address) 1126 Proctor

15-

Filed....., 191.....

Registrar.

APR 28 1921 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, ~~autopsy or inquiry~~.) thereon and from the evidence obtained by said..... (Inquest, ~~or inquiry~~) ..... find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull & Crushed body

(Duration) a few seconds

CONTRIBUTORY (Secondary) Struck by United R.R. Car

(Duration) ..... yrs. a few seconds

(Signed) W. B. Fowler M. D. (Coroner.)

3-28, 1921 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Bald Cemetery	Mar 29, 1921
20-UNDERTAKER	ADDRESS
Mrs Cook	502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52388 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52388

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 N Monroe ST.; 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lana V Johnson

(a) RESIDENCE. No. 801 N Monroe ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph H Johnson

6 DATE OF BIRTH (month, day, and year) Dec 9 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ab 837

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Christian Rosenbush

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Ann G Hess

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Edwin M Johnson

(Address) Roseneath Ave Catonsville

15 Filed Mar 28 1921 Robert P. Harrison, Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar, 1920, to Mar 26, 1921, that I last saw h[illegible] alive on Mar 26, 1921, and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

1st 6 Months Septicitis and Carcinoma of Uterus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) about yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter E. Twickmeier, M. D.

Mar 27, 1921 (Address) 2002 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Mar 29 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.52389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.52389

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 36 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Scheu

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ~~unknown~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowdd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
89				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed Robert P. Harrison, Registrar

3-28-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921 to March 28, 1921 that I last saw her alive on March 27, 1921 and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis. (No cerebral hemorrhage.)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No special test.

(Signed) P. Heeman, M. D.

3-28-1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 30 1921

20 UNDERTAKER: Lombard ADDRESS: 552 E Fayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.52390

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.52390

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2205 Hunter Alley St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Masuria Jones

(a) RESIDENCE. No. 2205 Hunter Alley St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1868

7 AGE: Years 53 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Att Home

(b) General nature of industry, business, or establishment in which employed (or employer) 900

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Horace Jones

(Address) 2205 Hunter Alley

15 Filed 19 Robert P. Harrison, Registrar

R281921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1920, to March 27, 1921, that I last saw her alive on March 27, 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart Disease

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. C. Johnson. M. D.

, 19 (Address) 211-E-25th St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: March 19 21.

20 UNDERTAKER: Mechanic Co.

ADDRESS: 502 E. N. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 52391

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52391

CERTIFICATE OF DEATH.

1/30

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 Edmondson ave ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgeanna Whalen

(Residence in Baltimore: No. 1419 Edmondson ave St. Life yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, Feb (Month) 13 (Day), 1840 (Year)

7-AGE, 81 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, J. McNeil

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Gertrude Whalen

(Address) 1419 Edmondson Ave

15-

Filed Apr 28 1921 Robert P. Harrison, Registrar.

AR 28 1921

Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1 1921, to March 27 1921, that I saw h[er] alive on March 25, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows: Senile nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uraemia Coexisting

(Duration) yrs. mos. 7 ds.

(Signed) G. G. Rush M. D.

3-27, 1921 (Address) Charles & Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	March 29 1921
20-UNDERTAKER James Dignan & Son	ADDRESS 1000 S. Paca St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52392 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 E. Federal ST.: 9 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Annie Brown

(a) RESIDENCE. No. 1219 E. Federal ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Brown

6 DATE OF BIRTH (month, day, and year) Aug 14 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Pauline Feitel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa

14 Informant Howard Brown (Address) 1219 E. Federal St

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6th, 1920, to Mch 27, 1921, that I last saw her alive on Mch 27, 1921, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Arthritis. acute

(Streptococcic poisoning)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No

(Signed) Hugh Forsythe, M. D.

, 19 (Address) 424 E. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Thu 30 1921
20 UNDERTAKER	ADDRESS
Wm J Ruckert & Sons	North Av

3-31-1921

TION is very important. See instructions on back of certificates. ... may be properly classified. Exact statement ... OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. Forsythe
424 E. North Ave
Chronic Rheumatic
Infectious endocarditis

Spec.—6-9-19—H. P. Co.—1600 Blks.

D.52393 HEALTH DEPARTMENT—CITY OF BALTIMORE D.52393

154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1109 W Cross St.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kinsella

(a) RESIDENCE. No. 1009 W Cross St., WARD. 21

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Kinsella

6 DATE OF BIRTH (month, day, and year) 2 Mar 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Flagman

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer B O R R

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Rose Kinsella (Address) 1049 W Cross

15 Filed Mar 4 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to Mch 27, 1921, that I last saw him alive on Mch 26, 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Old age and
General Debility

(duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Hx General Observation

(Signed) Joseph E. Muse, M. D.

Mch 28 1921 (Address) 520 Hollins ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Interment Cemetery	Mch 29 1921
UNDERTAKER	ADDRESS
H. Kluskens & Sons	Norwood

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.52394 HEALTH DEPARTMENT—CITY OF BALTIMORE D52394

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 McCabe ave ST.: 27 WARD)

2-FULL NAME John Cain.

(a) RESIDENCE. No. 509 McCabe ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? 68 yrs. — mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Cain.

6 DATE OF BIRTH (month, day, and year) July 12th 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) — 030

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER John Cain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E. Cain (Address) 509 McCabe ave

Filed 3-28-1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug-1- 1920, to March 27, 1921, that I last saw him alive on March. 26, 1921, and that death occurred, on the date stated above, at 10.35 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron Interstitial Nephritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Klein, M. D.

3,28, 1921 (Address) 5600 York Rd Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mar 30" 1921
20 UNDERTAKER	ADDRESS 2236
Wm J. Hartwell,	W. Baltimore St

TION is very important. See instructions on back of certificates.

20.52395 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.52395

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead at 47 REGISTERED No. C

CITY OF BALTIMORE (No. Franklin St Hospital ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara E Boland

(Residence in Baltimore: No. 531 S Mansfield St.; yrs., Life mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 22 (Day), 1870 (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Bolte

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Sarah Leighton

13-BIRTHPLACE OF MOTHER (State or Country) Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Fenimore

(Address) 2161 Hollins

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

APR 1 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis
Rheumatic

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James McFenton M. D.
(Coroner.)

Mar 27, 1921 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

1836 N Charles St

Former or usual residence 531 S Mansfield St

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery. DATE OF BURIAL, Mar 29, 1921.

20-UNDERTAKER Wm J Hartwell. ADDRESS 2236 W. Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52396

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 52396

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1535 W Fayette ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy A Carroll

(a) RESIDENCE. NO. 1535 W Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John T Berry
(Address) 1535 W Fayette St

15 Filed 19 Robert F Harrison
Registrar

R 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26th 1921 19

17 I HEREBY CERTIFY, That I attended deceased from January, 1921, to March 26, 1921, that I last saw h— alive on March 25, 1921, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward V. Cockeban, M. D.

3/28, 1921 (Address) 74 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Mar 29th 1921
20 UNDERTAKER	ADDRESS 2236
Wm J. Hartwell & Co.	W. Baltimore St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52397

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52397

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Columbia av ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Farnaugh

(a) RESIDENCE. No. 1212 Columbia ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband

6 DATE OF BIRTH (month, day, and year): June 10th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Frank Cobb

(Address) 1212 Columbia av

15 Filed MAR 29 1921 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 27 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 25, 1921, to March 27, 1921,

that I last saw h.... alive on Mar 26, 1921,

and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Bright, M. D.

3-27 1921 (Address) 602 Columbia av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Mar 31 1921
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Fayette

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52398 HEALTH DEPARTMENT—CITY OF BALTIMORE D52398

CERTIFICATE OF DEATH.

8-041

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 3916 Eastern Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis J. Melley.

(a) RESIDENCE. No. 3916 Eastern Ave ST., 26 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20-1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Melley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Anna Kusko

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant James Melley
(Address) 3916 Eastern Ave.

15 Filed MAR 29 1921 ROBERT A CARTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1921, to Mar 28, 1921, that I last saw him alive on Mar 27, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Francis Tilden, M. D.

3/28. 1921 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Mar 29 1921
20 UNDERTAKER Lilly and Zieler.	ADDRESS 403 S Wolfe St.

Make sure should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52399 HEALTH DEPARTMENT—CITY OF BALTIMORE D52399

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 Warren Ave ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Smith B. Dewed

(a) RESIDENCE. NO. 301 Warren Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances M. Good Dewed

6 DATE OF BIRTH (month, day, and year) Aug 28 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Sash Weight x

(c) Name of employer Sheet Metal Print

9 BIRTHPLACE (city or town) (State or country) New York State

PARENTS

10 NAME OF FATHER George L. Dewed

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York State

12 MAIDEN NAME OF MOTHER Louise Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York State

14 Informant Louise Dewed (Brother)

(Address) 301 Warren Ave

15 Filed MAR 29 1921 ROBERT A. KEATER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1921

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to Mch 26, 1921, that I last saw him alive on Mch 26, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Omentum.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F. Edward Smith, M. D.

, 19 (Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK	MAR 29 1921
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST

TION is very important. See instructions on back of certificates.

D 52400

D 52400

D 52400

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Hanover ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Gertrude Labuhn

(a) RESIDENCE. NO. 1619 Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry J. Labuhn

6 DATE OF BIRTH (month, day, and year) Mar 8

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Roberts

11 BIRTHPLACE OF FATHER (city or town) Ellicott
(State or country) Md

12 MAIDEN NAME OF MOTHER Sidney Sears

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Md

14 Informant Henry J. Labuhn
(Address) 1619 Hanover St

15 Filed MAR 29 1921 ROBERT A. [illegible]
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1921 to Mar 26 1921, that I last saw h[illegible] alive on Mar 26 1921, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. [illegible] M. D.

3/26 1921 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MOUNT OLIVET.	MAR 29 1921

20 UNDERTAKER JOHN F. DENNY ADDRESS 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D52401

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 745 W. Baltimore St. St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Parrish

(a) RESIDENCE. No. 745 W. Baltimore St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan R. Parrish

6 DATE OF BIRTH (month, day, and year) Aug. 12" 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 0"

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) "

12 MAIDEN NAME OF MOTHER Unknown "

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) "

14 Informant Mrs. Chas. E. Stein (Address) 745 W. Baltimore St.

15 Filed MAR 29 1921, 19 ROBERT J. BRAUER Registrar

Burial in Mt. Olivet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 27" 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1921, to Mch 27, 1921, that I last saw h alive on Mch 27, 1921, and that death occurred, on the date stated above, at 12.40 Noon.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

Mch 29 1921 (Address) 937 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Mar 29 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W Baltimore Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

138 D52402.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Welty

(a) RESIDENCE. No. 1821 N. Chapel ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a ~~If married, widowed, or divorced~~ (~~HUSBAND~~ or ~~WIFE~~) of Guy Welty

6 DATE OF BIRTH (month, day, and year) ~~July~~ 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	17	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va.

12 MAIDEN NAME OF MOTHER Lassie Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant G. Willigus Welty

(Address) 1821 N. Chapel St

15 Filed ....., 19.... [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28 1921

17

I HEREBY CERTIFY, That I attended deceased from 3/27, 1921, to 3/28, 1921, that I last saw h.. alive on 3/28, 1921, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Eclampsia (puerperal)

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. L. Stone, M. D.

3/28. 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	April 1 1921
20 UNDERTAKER	ADDRESS
A. Sander Sons	1710 Pennsylvania

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D52403

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D52403

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 521 N. Lakewood Ave WARD 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E. Cromwell

(a) RESIDENCE. No. 521 N. Lakewood Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia A. Cromwell

6 DATE OF BIRTH (month, day, and year) Oct 16, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sail maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. Government

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George W. Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Julia Cromwell (Address) 521 N. Lakewood Ave

15 FILED MAR 29 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to March 27, 1921, that I last saw h[illegible] alive on March 27, 1921, and that death occurred, on the date stated above, at 12 45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. J. G. Owens M. D.

March 28. 1921 (Address) Fairmont Ave & Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar. 31 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St.

TION is very important. See instructions on back of certificates. Enter statement of OCCUPA- may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52404

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52404

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 404 Forest Road ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonia Marie Louise Waters

(a) RESIDENCE. No. 404 Forest Road ST. 27 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 90 yrs. 7 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew G. Waters

6 DATE OF BIRTH (month, day, and year) Aug-9-1830

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Philadelphia

(State or country) Penna.

PARENTS

10 NAME OF FATHER George F. Womrath

11 BIRTHPLACE OF FATHER (city or town) unknown

(State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Herwig

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Alice H. Baer (daughter)

(Address) 404 Forest Road City.

15 Filed MAR 29 1921 ROBERT J. KRAUTER Registrar

Burial Permit Oled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1914, to Mar-27, 1921, that I last saw h[illegible] alive on Mar-27, 1921, and that death occurred, on the date stated above, at 11-35 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio-sclerosis (duration) 7+ yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) —— (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M. J. Pizlo M. D.

3/28, 1921 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Mar-29-1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No Haemorrhages.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52405 HEALTH DEPARTMENT—CITY OF BALTIMORE D52405

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2110 Harford Ave. ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin H. Graff.

(a) RESIDENCE. No. 2110 Harford Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 25nd 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Martin J. Graff.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Myrtle S. Heath

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Martin J. Graff,
(Address) 2110 Harford Ave

15 Filed MAR 29 1921 ROBERT J. KEISER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1921

I HEREBY CERTIFY That I attended deceased from March 25 21, 19..., to March 28, 19 21, that I last saw h... alive on March 28, 19 21, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Wyeroad M. D.

3/29/21 (Address) 801 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	March 29 1921
20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Balto.

TION is very important. See instructions on back of certificates.

45 until 10

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52406 HEALTH DEPARTMENT—CITY OF BALTIMORE D52406

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N Pulaski St.; 20 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gengianna E Bronflick

(a) RESIDENCE. No. 514 N Pulaski St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W Bronflick

6 DATE OF BIRTH (month, day, and year): Jan 15 1857

7 AGE: Years 64 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel W Pritchard

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John W Bronflick

(Address): 514 N Pulaski St

15 Filed MAR 29 1921 ROBERT A LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 28 21

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1921, to March 28, 1921, that I last saw h[illegible] alive on March 27, 1921, and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Paresis. Gradual weakness of heart action.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Hemiplegia - L. side

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Gradual paresis and paralysis of L. side

(Signed) F. H. Phillips M.D.

, 19 (Address) 2300 Edmondson.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem't Md	1924
20 UNDERTAKER	ADDRESS
Wm Cahoon & Enoba	

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...ll it may be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Luetic

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52407

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52407

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (2761 Et Fairmount Ave 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert R Hoaft

(a) RESIDENCE. 2761 Et Fairmount Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19/1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Charles R Hoaft

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Liseal Cobey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Charles R Hoaft
(Address) 2761 Et Fairmount Ave

15 FILED MAR 29 1921 ROBERT J. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Mch 20 1921, to Mch 29 1921, that I last saw him alive on Mch 28 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Health Dpt

(Signed) W. F. Smith, M. D.

3-29 1921 (Address) 1184 N Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemt — DATE OF BURIAL: Mar 24 1921

UNDERTAKER: W Bachrach & Nathan — ADDRESS

IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Jaeger.

D52408

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52408

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2427 Pennsylvania Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antony Jaeger

(a) RESIDENCE. No. 2427 Pennsylvania Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Minnie Jaeger

6 DATE OF BIRTH (month, day, and year) Oct 11, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Antony Jaeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mrs Jaeger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Jaeger (Address) 2427 Pennsylvania Ave

15 Filed MAR 29 1921 ROBERT J. BRADEN Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1920, to March 27, 1921, that I last saw h. alive on March 26, 1921, and that death occurred, on the date stated above, at 4a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Chronic)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W J Gray, M. D.

3/29, 1921 (Address) 627 N. Montford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Mar 30 1921

20 UNDERTAKER Jonah Syfe ADDRESS 1600 N Monroe

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-52409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-52409

104 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 So Spring st ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kovek

(a) RESIDENCE. No. 131 So Spring ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18-1921

7 AGE — Years — Months 11 Days If LESS than 1 day, ... hrs. or ..... min.

~~March 18~~ — 1921

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Kovek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Stapan Grigonk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant John Kovek
(Address) 131 S. Spring St

15 Filed , 19 ROBERT J. KRAUTER Registrar

MAR 29 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1921

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1921, to March 29, 1921, that I last saw him alive on March 28, 1921, and that death occurred, on the date stated above, at 2 30 p. m.

The CAUSE OF DEATH* was as follows:

Empillema, Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis over

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) W. J. Barfin, M. D.

3/29, 1921 (Address) 210 Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 31 1921
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Ponca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Diarrhoeal gastritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

147063 D-52410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. D-52410

REGISTERED NO. 30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelina Marcello

(a) RESIDENCE. No. 229 N. Chapel St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27—1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Eng Rondello

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Madelina Sylvestri

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Hospital Record

15 Filed MAR 29 1921 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1921

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1921, to March 28, 1921, that I last saw h-e alive on March 28, 1921, and that death occurred, on the date stated above, at 3:55 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) W. Dawson, M. D.

March 29, 1921 (Address) 1114 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	3/29/1921
20 UNDERTAKER	ADDRESS
Philip Herwig	Aliceanna 2016

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D-52411 HEALTH DEPARTMENT—CITY OF BALTIMORE D-52411

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 813 N. Belnard Ave. ST.; 7 WARD)
2-FULL NAME Carrie L. Berry
(Residence in Baltimore: No. 813 N Belnard)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

Registered No. C

49 - 5 - 23
(St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem.
4-COLOR OR RACE, Wht
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Wid

6-DATE OF BIRTH, Oct 3rd, 1871
(Month) (Day) (Year)

7-AGE, 49 - 5 - 23
49 yrs. mos. ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country): City

PARENTS.
10-NAME OF FATHER, Brown
11-BIRTHPLACE OF FATHER (State or Country), Md.
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Herald L. Berry
(Address) 813 N. Belnard Ave

15- MAR 29 1921 ROBERT F. KRAUSE
Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. K. Wiesler M. D.
(Coroner.)
3-28-1921 (Address) 7 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem. DATE OF BURIAL, 3/29, 1921
20-UNDERTAKER Philip Henrig ADDRESS 2016 Allens

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

11

0751
52412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

402 52412

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME German Laurence

(a) RESIDENCE. No. 2738 W Baltimore St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 4 ds. How long in U. S., If of foreign birth? —— yrs. —— mos. —— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married

5 If married, widowed, or divorced.
HUSBAND of (or) WIFE of Carrie Laurence

6 DATE OF BIRTH (month, day, and year) July 24 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaiah Laurence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabelle Baldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAR 29 1921 ERNEST J. REUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1921, to March 26, 1921, that I last saw h[illegible] alive on March 26, 1921, and that death occurred, on the date stated above, at 12 40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach.

(Symptoms) (duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Severe secondary anaemia

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? Yes Date of March 1921

Was there an autopsy? No

What test confirmed diagnosis? Pathological (gross)

(Signed) Harry H. Plath, M. D.

, 19 (Address) Johns Hopkins Hosp Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	March 29 21
20 UNDERTAKER	ADDRESS
A B Huppert	2236 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spmr.—6-9-19—H. P. Co.—1000 Bks.

D62413 HEALTH DEPARTMENT—CITY OF BALTIMORE D52413

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore and Payson Sts. 130

CITY OF BALTIMORE: (NO. German Aged Home ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Lotterer

(a) RESIDENCE. NO. German aged Home ST.: WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 25 1841

7 AGE — Years: 80 — Months: — — Days: 2 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown "

14 Informant: German Aged Home Records (Address) Balto and Payson Sts.

15 FILED MAR 29 1921 ROBERT P. BRAUER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept ..., 19 20, to Mar 27, 19 21, that I last saw her alive on Mar 26, 19 21, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with general anasarca

(duration) many yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. W. Habelmann, M. D.

, 19 (Address) German aged home.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mathews Cem. DATE OF BURIAL: Mar 29 19 21

20 UNDERTAKER: Joseph L. B. Cook ADDRESS: 1003 N. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52414

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52414

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Church Home & Infirmary ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Bowie Coward-

(a) RESIDENCE. NO. Church Home & Infirmary ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	93			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Talbot Co. Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas R Coward

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Talbot Co Md

12 MAIDEN NAME OF MOTHER Margret Graham

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Madie F Hughlett
(Address) St Paul Apts

15 Filed MAR 29 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28- 1921.

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1920, to Mar. 28, 1921, that I last saw her alive on Mar. 28, 1921 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam of chest

(Signed) Medical Staff, M. D.

, 19 (Address) Church Home & Infr.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Mar 30 1921
20 UNDERTAKER	ADDRESS
Henry Watkins Sons	Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52415 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D. 52415

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St. 70 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Linsenmaier

(a) RESIDENCE. No. 303 S Bentalou St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margarette Linsenmaier

6 DATE OF BIRTH (month, day, and year) April 22. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	11.	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) at R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marguerite Linsenmaier

(Address) 303 S. Bentalou St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

R 29 1921 Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 22, 1921, to Mar. 28, 1921, that I last saw h[illegible] alive on Mar. 28, 1921, and that death occurred, on the date stated above, at 10.20 a m.

The CAUSE OF DEATH* was as follows:

Chronic suberatilied nephritis

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. McElwain, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	March 30. 1921
20 UNDERTAKER C. W. Dill	ADDRESS 1309 Fredk Ave;

D. 52416

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1462 D. 52416

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1820 Eutaw Place ST. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ida Rosenberg

(Residence in Baltimore: No. 1705 E. Lombard St.: 13 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March 4, 1900 (Month) (Day) (Year)

7 AGE: 21 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Clothing Worker
(b) General nature of industry, business, or establishment in which employed (or employer): 080

9 BIRTHPLACE (State or country): Russian Poland

PARENTS

10 NAME OF FATHER: Meyer Rosenberg

11 BIRTHPLACE OF FATHER (State or country): Russian Poland

12 MAIDEN NAME OF MOTHER: Freda Kloze

13 BIRTHPLACE OF MOTHER (State or country): Russian Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Yetta Fram

(Address) 1711 Westwood ave

15

MAR 29 1921

Robert P. Harrison, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 29, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1921 to Oct. 29, 1921 that I saw h[illegible] alive on Oct 29, 1921 and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Bilateral Ethmoiditis, Sphenoiditis

(Duration) 15 yrs. ... mos. ... ds.

Contributory (SECONDARY) Acute Septic Meningitis

(Duration) ... yrs. ... mos. 4 ds.

(Signed) Isadore Lee M.D.

March 29, 1921 (Address) 1820 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Hebrew Rodelph — DATE OF BURIAL: 3/30 1921

20 UNDERTAKER: Isaak Lewis — ADDRESS: 1411 E. Balto St

D. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52417 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52417

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 917 N. Washington ST.; (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Svoboda

(a) RESIDENCE. NO. 917 N. Washington ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? 14 yrs. 2 mos. 17 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year) 12. 30. 06.

7 AGE — Years: 14 | Months: 2 | Days: 27. | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Anton Svoboda

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Mary Lissa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Anton Svoboda

(Address): 917 N. Washington

15 Filed ....., 19.... Harrison, Registrar

R 291921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH*

16 DATE OF DEATH (month, day, and year) 3. 26. 1921.

17 I HEREBY CERTIFY, That I attended deceased from March 9 1921, to March 26 1921, that I last saw him alive on March 26 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease

(duration) 14 yrs. 2 mos. 27 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What [illegible] diagnosis? Clinical

(Signed) Wm. A. D. McGinn, M. D.

28, 19 21 (Address) 1031 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: March 30 1921

20 UNDERTAKER: Frank Crock Son — ADDRESS: 1906 Eutaw Pl.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.52418 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52418

CERTIFICATE OF DEATH. X 162

1-PLACE OF DEATH

CITY OF BALTIMORE (No. in B & O R.R. track St. 22 (WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johnnie Valentine Harris

(Residence in Baltimore: No. — San Francisco Cal. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	W.	

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 78 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION: (a) Trade, profession, kind of work Retired Minister (b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany,

PARENTS.

10-NAME OF FATHER, Don't Know,

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Brooks

(Address) Calhoun Hollins sts

15- Robert F. Harrison,

Filed ....., 191.....

MAR 23 1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & internal Injuries

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Injured from Bro R. R. Train at Wadsworth Rd

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. K. Gonsch M. D. (Coroner.)

3-28, 1921. (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Weibold San Francisco Cal. DATE OF BURIAL, Mar. 29, 1921.

20-UNDERTAKER Robert Brookes ADDRESS Calhoun Hollins sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52419 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 52419

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2539 N Fouldord ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas J. Frosch

(a) RESIDENCE. No. 2539 N Fouldord ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morgent. Frosch

6 DATE OF BIRTH (month, day, and year) Feb-7-1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sausage Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jos Philips Bro.

9 BIRTHPLACE (city or town). (State or country) Md. Baltimore Co.

PARENTS

10 NAME OF FATHER Geo. H. Frosch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lucy Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr. Harley Mullo

(Address)

15 Dec. 19 Robert P. Harrison, Registrar

MAR 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. - 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1920, to Mar - 28, 1921, that I last saw him alive on Mar - 27, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory and Clinical

(Signed) Wesley Cole, M. D.

3/28 1921 (Address) 2702 Gunston Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Mar 30 1921
20 UNDERTAKER	ADDRESS 1037
E Schloman & Son	Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Ehrman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52420

CERTIFICATE OF DEATH.

65

D 52420

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 N. Fulton Ave. ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Frodnicka Gehrman Ehrman

(Residence in Baltimore: No. 921 N. Fulton Ave St.; 75 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	widiwed

6-DATE OF BIRTH, Dec 11 1837
83 (Month) 3 (Day) 17 (Year)

7-AGE, 83 yrs. 3 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matilda Ehrman

(Address) 921 N. Fulton

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.

MAR 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 20 1921, to Mar 28 1921, that I saw her alive on Mar 28 1921, and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH* was as follows:

..... Cerebral softening .....
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteria-sclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. H. Ehrman M. D.
3/25/21, 191... (Address) 735 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Mch. 31. 1921

20-UNDERTAKER	ADDRESS
H.E. Hughes	424 N. Broadway

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52421

CERTIFICATE OF DEATH.

92-010

D 52421

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE) (No. 1413 Covington ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eliza H. Hemming

(a) RESIDENCE. No. 1413 Covington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Hemming

6 DATE OF BIRTH (month, day, and year) July 31-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER John J. Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary C. Conway.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Marion H. Rogers
(Address) 1415 Covington St

15 Filed Robert P. Harrison, Registrar
R 2 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 27, 1921, that I last saw her alive on March 27, 1921, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Ca Uterus

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. J. Whetzel M. D.

3/27 1921 (Address) 1279 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	3/30 1921
20 UNDERTAKER Margaret G. F. Lynn	ADDRESS 1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52422

CERTIFICATE OF DEATH.

63

D 52422

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 N. Port. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias S. Felty.

(a) RESIDENCE. No. 417 N. Port ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed,~~ or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Sarah J. Felty

6 DATE OF BIRTH (month, day, and year): Feb 20 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman 67

(b) General nature of industry, business, or establishment in which employed (or employer): W. Ind. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): South Amphton Pa

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Sarah J. Felty (Address) 417 N. Port St.

15 Filed MAR 29 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25 1921

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 28, 1921, that I last saw h.. alive on March 27, 1921, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) C. G. Deaver, M.D.

3/29, 1921 (Address) 2000 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Orems Cemetery	March 30 1921
20 UNDERTAKER	ADDRESS
Jas. C. Miller	2334 Jefferson

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52423 ✓ D 52423

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3006 Sloffard St. 20 WARD)

2-FULL NAME Edward Sheehan

(a) RESIDENCE. NO. 3006 Sloffard ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec 15 1887

7 AGE — Years: 33 — Months: 3 — Days: 11 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Adolphus Sheehan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Me

14 Informant: Mrs Mary Myers

(Address) 3001 Sloffard St

MAR 30 1921 ROBERT E. LEAUTEY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8 1921, to March 28 1921, that I last saw him alive on March 27 1921, and that death occurred, on the date stated above, at 12-25 P m.

The CAUSE OF DEATH* was as follows:

1. Tuberculosis Pulmonalis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones M. D.

(Address) 3-28-21 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: 3/30 19

20 UNDERTAKER: Geo A Starky Sulton & Forgett — ADDRESS

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52424

D 52424

151

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3450 Elm ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME unnamed infant son of Thos. & Bard Goodman

(Residence in Baltimore: No. 3450 Elm ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, March 29, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.
If LESS than 1 day, 2 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 0
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Thos. Goodman

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Ocie Mahone

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Goodman

(Address) 3450 Elm av

15-MAR 30 1921 ROBERT J KRAUTER
Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 29, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 29 9 am 1921, to Mar 29 11 am 1921, that I saw him alive on March 29 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:
5th Month Gestation
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Mar 29 1921 (Address) 865 N 36th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, March 31 1921

20-UNDERTAKER Chesnowith & Son — ADDRESS Chestnut ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52425 HEALTH DEPARTMENT—CITY OF BALTIMORE D52425

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3634 Cedar Ave 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia Morlok

(a) RESIDENCE. No. 3634 Cedar Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Mar 29 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) MD
(State or country)

PARENTS

10 NAME OF FATHER John Morlok

11 BIRTHPLACE OF FATHER (city or town) MD
(State or country)

12 MAIDEN NAME OF MOTHER Hattie Jingling 3-29-1921

13 BIRTHPLACE OF MOTHER (city or town) MD
(State or country)

14 Informant Hattie Morlok
(Address) 3634 Cedar Ave

15 Filed MAR 30 1921 ROBERT I. KRAMER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 1921

17

I HEREBY CERTIFY, That I attended deceased from March 29 1921 to March 21 1921

that I last saw her alive on March 29 1921

and that death occurred, on the date stated above, at 11 10 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth —
6 months gestation

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) C. J. Davies, M. D.

1921 (Address) 880 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Frames Abington MD	Mar 29 1921
20 UNDERTAKER	ADDRESS
Chenowett & Son	Chestnut Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52426 HEALTH DEPARTMENT—CITY OF BALTIMORE **D 52426**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 Madison Avenue St. 11 WARD)

REGISTERED No. C 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine C'Neill

(Residence in Baltimore: No. 801 Madison Avenue St., Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct 21, 1866.
(Month) (Day) (Year)

7-AGE, 54 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Lint

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Rackenstorg

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lennie Burke

(Address) 603 Dukeland Ave

15- MAR 30 1921 ROBERT J. KRAUTER Registrar.
Filed....., 191.....
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 29, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 24th 1921, to Mch. 29th 1921, that I saw h[er] alive on Mch 29th 1921, and that death occurred, on the date stated above at 3 A. m.

The CAUSE OF DEATH* was as follows: Bronchio Pneum

(Duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Pott's Dis. of Spine

(Duration) yrs. Life mos. ds.

(Signed) A. Ten Eyck M. D.

Mch 29, 1921. (Address) 924 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem	Sept 1st, 1921
20-UNDERTAKER	ADDRESS
Henry H Jenkins Sons Co	Richard & Mc Culloh Sts

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52427

D 52427

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 W. Henrietta St. ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Mathews

(a) RESIDENCE. No. 125 W. Henriette ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 21 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	1	9	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston W-Va

12 MAIDEN NAME OF MOTHER Ella O'neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Samuel Mathews
(Address) 125 W. Henrietta St

15 Filed MAR 3 0 1921 19 ..... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/21, 1921, to 3/28, 1921, that I last saw him alive on 3/28, 1921, and that death occurred, on the date stated above, at 6:40 p m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. ..... mos. 26 ds.

CONTRIBUTORY (Secondary) Gastric catarrh

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. O. Robinson M. D.

(Address) 1520 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Mch 31 1921
20 UNDERTAKER	ADDRESS
J. B. Brown & Son	1089 Mont-

D 52428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52428

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 805 S. Sharp St. ST. 22 150 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Robinson. (C)

(Residence in Baltimore: No. 805 S. Sharp St. St.: yrs.---- mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH, March 7th. 1921, 1
(Month) (Day) (Year)

7-AGE, ----yrs. ----mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Williams. (C)

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-~~MAIDEN~~ NAME OF MOTHER Mary Robinson. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Robinson. (C) mother.

(Address) 805 S. Sharp St.

15-

Filed MAR 30 1921, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 27th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency.
congenital.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

March 28 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn ct	March 30, 1921
20-UNDERTAKER	ADDRESS
C. L. Brown & Son	1084 W. Pratt st

Burial Permit

Please fill out all items in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52429 D 52429 D 52429

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 N. Hilton ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Good Neall

(a) RESIDENCE. No. 606 N. Hilton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phila
(State or country) Pa

PARENTS

10 NAME OF FATHER Abram W Haines

11 BIRTHPLACE OF FATHER (city or town) Phila
(State or country) Pa

12 MAIDEN NAME OF MOTHER Letitia Quimby

13 BIRTHPLACE OF MOTHER (city or town) Phila
(State or country) Pa

14 Informant B F Duvall
(Address) 606 N. Hilton St

15 Filed ....., 19.... Registrar

MAR 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1921

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1920, to Mch 28, 1921.

That I last saw her alive on Mch 27, 1921,

and that death occurred, on the date stated above, at 5-0 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bowel.

(duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Septic Auto intoxication

(duration) ✓ yrs. 2 mos. ✓ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No

(Signed) Geo E Shannon, M. D.

3/29 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia. Pa	Mar 30 1921
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	North Pa

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52430 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52430

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 N. Stricker St. ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Fine

(a) RESIDENCE. No. 1100 N Stricker St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	21	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Frank Fine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Binder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Louis 1411 E Baltimore St

15 Filed MAR 30 1921, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1920, to March 29th, 1921, that I last saw h[illegible] alive on March 29, 1921, and that death occurred, on the date stated above, at 5 H m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis with mitral regurgitation

(duration) 2 yrs. (?) mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) 1 yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Indefinite

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Benj. Kaden, M. D.

, 19 (Address) 252 N. Payson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 3/30 1921

20 UNDERTAKER Jack Levin

ADDRESS 1411 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52431

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 Druid Hill Ave St. 14 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milburn Taylor

(a) RESIDENCE. No. 1904 Druid Hill Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Café

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Colbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rachel Taylor
(Address) 1904 Druid Hill Av

15 Filed MAR 30 1921 ROBERT [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1921

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to March 28, 1921, that I last saw h[illegible] alive on March 27, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis 1 yrs. mos. ds.
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Harry S McCard M. D

3/30 1921 (Address) 2005 Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Auburn Cem	Mar 31 1921
20 UNDERTAKER	ADDRESS
Geo W Holland	1631 Druid Hill Ave

CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52432

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 248 Bruce ST.; 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Atkinson

(Residence in Baltimore: No. 248 Bruce St.; 10 yrs., ... mos. ..... ds.)

important. See instructions on back of certificate. Each statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	Colored	Single

6-DATE OF BIRTH, June 23rd, 1910.
(Month) (Day) (Year)

7-AGE, 10 yrs. 9 mos. 5 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Baltimore md

PARENTS.

10-NAME OF FATHER, George Atkinson

11-BIRTHPLACE OF FATHER (State or Country), Jamacia Island British West Indies

12-MAIDEN NAME OF MOTHER Ida Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Rondon

(Address) 248 Bruce St

15-

Filed MAR 29 1921, 191.... ROBT. J. BRADFORD Registrar.

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3/19 1921, to 3/28 1921, that I saw h.. alive on Mar 27 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever

..... (Duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) H. B. Hughes M. D.

3/28/21, 191... (Address) 765 W. Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Mar 30, 1921

20-UNDERTAKER Joseph J. Farrell — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52433

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

D 52433

PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 714 N Gilmor St 16 ST.; WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Miss Lida Helsby

(Residence in Baltimore: No. 714 N Gilmor St St.; 77 yrs. 3 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Fem	White	Single

6. DATE OF BIRTH Jan 3, 1844 (Month) (Day) (Year)

7. AGE 77 yrs. 3 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or country) Balto Md

PARENTS

10. NAME OF FATHER Saml Helsby

11. BIRTHPLACE OF FATHER (State or country) Md

12. MAIDEN NAME OF MOTHER Elizabeth Holtz

13. BIRTHPLACE OF MOTHER (State or country) Balto Md

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Helsby

(Address) 714 N Gilmor

15. Filed MAR 30 1921 ROBERT J KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 29th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12th, 1921, to March 29 1921, that I saw her alive on March 28th, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

She had been ailing for seven months before death (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) advanced age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), John D Cunningham M. D.

March 30, 1921 (Address) 1826 Bolton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mt Olivet Cem DATE OF BURIAL 3/31/21

20. UNDERTAKER Jno J Smith ADDRESS 1000 W Pratt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52434

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52434

CERTIFICATE OF DEATH.

+ 113-091

1-PLACE OF DEATH US. Public Health Hosp. #56

REGISTERED NO.....

CITY OF BALTIMORE: (NO. Fort McHenry Baltimore Md. ST.: 24 WARD) N

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C. Walters.

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST., WARD. N
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 17 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) ----

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
32yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ----

9 BIRTHPLACE (city or town) ... (State or country) Kentucky

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) unknown

14 Informant Edgar T. Rosenbusch Registrar.
(Address) US. PHS. Hosp. #56 Ft. McHenry Md.

15 Filed MAR 30 1921 WILLIAM F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to March 27, 1921, that I last saw h... alive on March 27, 1921, and that death occurred, on the date stated above, at 6.10 p.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver, hypertrophic,

Pneumonia broncho.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy report

(Signed) Thomas B. Paynter M.D.
Senior Surgeon P.H.S.

3/29. 1921 (Address) US. PHS. Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Mar 30 1921
20 UNDERTAKER S. Levinson & Bro	ADDRESS 127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52435 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52435

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hospital #56 24 X 28 REGISTERED NO.....

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: ..... WARD) 30 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Pierce

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST., WARD. 30
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25 yrs.	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work waiter
(b) General nature of industry, business, or establishment in which employed (or employer) ---
(c) Name of employer -----

9 BIRTHPLACE (city or town) .....
(State or country) Ga.

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) unknown
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) unknown

14 Informant Edgar Isenbrock Registrar.
(Address) US. Public Health Hosp. #56 Ft Henry Md.

15 Filed ..... 19 ROBERT A. LAUTER Registrar
MAR 30 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to March 28, 1921, that I last saw him alive on March 28, 1921, and that death occurred, on the date stated above, at 6'45 a.m.

The CAUSE OF DEATH* was as follows:
Tuberculosi chronic pulmonary

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Thomas B. Payne M. D.
Senior Surgeon (R)
3/29 1921 (Address) US. PHS. Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington L. C
DATE OF BURIAL Mar 30 1921

20 UNDERTAKER S. Kleinman & Bro
ADDRESS 427 E Balto st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52436 64 D 52436

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5414 Park Heights ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter P. B. Morgan

(Residence in Baltimore: No. 5414 Park Heights St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Jan (Month) 6 (Day), 1869 (Year)

7-AGE. 57 yrs. 2 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Upholsterer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 085

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Walter S. Morgan

11-BIRTHPLACE OF FATHER (State or Country) Eng Land

12-MAIDEN NAME OF MOTHER Agnes Benson

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Morgan

(Address) 5414 Park Heights

15-

Filed MAR 30 1921 ROMER & KRAUTER Burial Permit Issued Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest and ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Woodside M. D. (Coroner.)

Mar 29 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	3/31, 1921.
20-UNDERTAKER William Cook	ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

3632 Roland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52437 ✓

CERTIFICATE OF DEATH.

D 52437
1-PLACE OF DEATH

120

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1205 W. Lanvale ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Powers

(a) RESIDENCE. No. 1205 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia E Powers

6 DATE OF BIRTH (month, day, and year) Feb 29 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance agent

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Geo Miller

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edwin V. Powers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Helen C Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Julia E Powers 1205 W Lanvale st

15 Filed MAR 30 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18th 1921, to March 29th 1921, that I last saw him alive on March 28th 1921, and that death occurred, on the date stated above, at 12:55 m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Convulsions, Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? — no —

What test confirmed diagnosis? Urine: Serum albumin

(Signed) L. B. Evans, M. D.

19 (Address) Greene & Franklin Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Mch. 31 1921

20 UNDERTAKER: Wm Cook — ADDRESS: W+G Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52438

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1621 N Baltimore ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Lyons

(a) RESIDENCE. No. 1621 N Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E Lyons

6 DATE OF BIRTH (month, day, and year) Mar 6 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 62

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Elec Ry Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hardesty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary E Lyons
(Address) 1621 N Baltimore St

15 Filed MAR 30 1921 ROBERT J. BRAUN, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 28th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Mar 28, 1921, that I last saw him alive on March 27, 1921, and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yr (?) mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) J. T. Burton, M. D.

3/28. 1921 (Address) 301 E Lems St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	3/30 1921
20 UNDERTAKER	ADDRESS
William Cook	508 North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92-010 D 52439

D 52439

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 261 S Highland Av ST.: 26 WARD)

2-FULL NAME Jena Lynch

(a) RESIDENCE. NO. 261 S Highland Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Lynch

6 DATE OF BIRTH (month, day, and year) June 14, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Holland

PARENTS

10 NAME OF FATHER Henry Deckers

11 BIRTHPLACE OF FATHER (city or town)..... (State or country) Holland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)..... (State or country) Holland

14 Informant Ella Jane Lynch
(Address) 261 S Highland Ave

15 Filed MAR 30 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1921, to Mar 29, 1921, that I last saw h~~e~~ alive on Mar 29, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tillow M. D.

3/30, 1921 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	April 1 1921
20 UNDERTAKER	ADDRESS
H. Sanders Sons	1710 Fleet St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...s may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52440

D 52440

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 n Chapel ST.; 7 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Thompson

(a) RESIDENCE. No. 1027 n Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Aylesford Md
(State or country) Lived in Balt 9 years

PARENTS

10 NAME OF FATHER Peter Thompson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Fannie Burns

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Cora Thompson
(Address) 1027 n chapel st

15 Filed MAR 30 1921 Robert A Knauth Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to Mar 28, 1921, that I last saw h[illegible] alive on Mar 26, 1921, and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

Incipient (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Exp Sputum

(Signed) Edw. Fisher, M. D.

3 29 1921 (Address) 1612 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	March 30 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 52441

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 247 So Boulden ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Balling

(a) RESIDENCE. NO. 247 So Boulden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred X yrs. 1 mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Mch. 2 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	X	X	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Balling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto - Md

12 MAIDEN NAME OF MOTHER Margaret Rhinehardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto -

14 Informant John Balling (Address) 247 So Boulden St

15 Filed MAR 30 1921 19 ROBERT I. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch. 28, 1921, to Mch. 29, 1921, that I last saw her alive on Mch 29, 1921, and that death occurred, on the date stated above, at 12, 15 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) X yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Lobular Pneumonia

(duration) X yrs. X mos. 2 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Jas. L. Shaw, M. D.

Mch 30 1921 (Address) 2456 2d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 3/30 1921

20 UNDERTAKER Philip Henrig

ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52442

CERTIFICATE OF DEATH.

150 D 52442

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Cossentino

(a) RESIDENCE. NO. 12 S Central Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Cossentino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Julia Cechimez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) East Md

14 Informant Hospital Record
(Address) J H H

15 Filed MAR 30 1921

ROBERT J. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14 1921, to March 26 1921, that I last saw h[illegible] alive on March 21 1921, and that death occurred, on the date stated above, at 2 55 p.m.

The CAUSE OF DEATH* was as follows:

Cellulitis

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Mar 15, 1921

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W Davison, M. D.

19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Friends	3/31/21
20 UNDERTAKER	ADDRESS
Wendell & Appel Adm	39 Lexington

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gangrenous Cumbilicus
of abdominal wall
Operation for drainage
of pus.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52443 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52443

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 884 Booth ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R. Johnson

(a) RESIDENCE. No. 884 Booth ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of - Juanita Johnson

6 DATE OF BIRTH (month, day, and year) 1845 Dec 15th

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lumberman - 1080

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER - Aaron Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER - E. Lodoock -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Georgie E. Johnson
(Address) 884 Booth St

15 Filed ..... 19 ..... Registrar

MAR 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/28, 1921, to 3/30, 1921, that I last saw him alive on 3/28, 1921, and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) Charles R. Goldsborough, M. D.

3/30, 1921 (Address) 2222 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	March 31st 1921
20 UNDERTAKER	ADDRESS
Samuel P. Hemsley	578 N. Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 52444

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. ~~Hospital~~ WARD 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Wheeler.

(a) RESIDENCE. NO. 610 Jasper ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lee Monroe

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER James Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Annie Wheeler
(Address) 610 Jasper St

15 Filed MAR 30 1921 ROBERT J. KRAUTER Registrar

Burial Permit Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 7, 1920, to March 27, 1920, that I last saw him alive on March 27, 1920, and that death occurred, on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Tub. Sputum.

(Signed) J. Digney, M. D.

3/30/1921 (Address) Bay view Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 30 1921
20 UNDERTAKER	ADDRESS
Samuel Kennedy	578 N Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80 D 52445

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2402 N Baltimore ST.: 20 WARD)

2-FULL NAME Chas Richter

(a) RESIDENCE. NO. 2402 N Baltimore ST. 20th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa M. Richter

6 DATE OF BIRTH (month, day, and year): Dec 16th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(h) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Henry G. Richter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Charlotte Seebach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md

14 Informant: Louisa M. Richter Sr.

(Address) 2401 N Baltimore

15 Filed MAR 30 1921

ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 27 1921

17 I HEREBY CERTIFY, That I attended deceased from February 2, 1921, to March 27, 1921, that I last saw h. alive on March 27, 1921, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Astero Sclerosis.

Angina Pectoris.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C Mitch, M. D.

3/28, 1921 (Address) 2151 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Mar 31 1921
20 UNDERTAKER	ADDRESS
H B Kappel	2336 Fredk Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52446

CERTIFICATE OF DEATH.

120 D 52446

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Shenks

(a) RESIDENCE. No. 510 S. Spring St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica

PARENTS

10 NAME OF FATHER Thomas Shenks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed MAR 30 1921 Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to March 25, 1921, that I last saw him alive on March 25, 1921, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis
(No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No especial test.

(Signed) B Herman, M. D.

3-25-1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
~~Bal~~ Laurel Cemetery	3/30/21

20 UNDERTAKER George J. Ruth ADDRESS 1735 ~~Hanford~~ Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Serszen

D 52447 D 52447 D 52447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-091 52447

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Lancaster ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalena Serszen

(a) RESIDENCE. No. 1609 Lancaster ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaus Serszen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Czeslawa Borowa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaus Serszen
(Address) 1609 Lancaster St

15 Filed MAR 30 1921 ROBERT J. BRAGUE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/29, 1921, to 3/29, 1921.

that I last saw him alive on 3/29, 1921.

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia & Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jay N. Swisher, M. D.

3/30 1921 (Address) 1623 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 30 1921
20 UNDERTAKER	ADDRESS
John P. Weber	1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52448

CERTIFICATE OF DEATH.

28

D 52448

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Morart

(a) RESIDENCE. No. 405 S. Gilmor st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Morart

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Deenhardt Jotz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.T.H.

15 Filed ..... 19 Robert T. Harrison, Registrar

AR 3 01921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from November 20, 1920, to March 29, 1921, that I last saw her alive on March 28, 1921, and that death occurred, on the date stated above, at 8.05 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in equtum, X-ray

(Signed) L. S. Fahndrich, M. D.

3-29-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cem	4/1 1921
20 UNDERTAKER	ADDRESS
Geo A Jordy Fulton & Fayette	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52449

CERTIFICATE OF DEATH.

1920 D 52449

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2107 Hollins St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Stronck

(Residence in Baltimore: No. 2107 Hollins St.; 70 yrs., ~ mos. ~ ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Not Known, ..., 1..... (Month) (Day) (Year)

7-AGE, 70 yrs. ~ mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Jno. Minnick

11-BIRTHPLACE OF FATHER (State or Country), Balto Co.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eliz. Stronck

(Address) 2107 Hollins St.

15-

Filed ....., 191.....Harrison..... Registrar.

MAR 30 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 1919, to March 1921, that I saw her alive on March 28th 1921, and that death occurred, on the date stated above, at 5.55 P.M.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs
General acites
(Duration) ~ yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis
(Duration) 2 yrs. ~ mos. ~ ds.

(Signed) Joseph H. Saunders M. D.

March 29, 1921. (Address) 217 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 3/31, 1921

20-UNDERTAKER George H. Shirley ADDRESS Fulton & Clyde

D 52450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52450

105

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1623 Argyle Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Dilver

(Residence in Baltimore: No. 1623 Argyle Ave St.; 14 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	Married

6-DATE OF BIRTH, Feb. 4, 1884
(Month) (Day) (Year)

7-AGE, 37 yrs. 1 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Abel Dilver

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Sarah Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nannie Dilver

(Address) 1623 Argyle Ave

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.

MAR 30 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cystitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

March 29 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Middleback Lancaster Co. Pa.

DATE OF BURIAL, Mar 30 1921

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 N. Carey

CAUSE OF DEATH in plain terms. Abbreviations are strictly objectionable. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D 52451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52451

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 S. Charles ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret O'Connell

(a) RESIDENCE. No. 1404 S. Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael O'Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jas. P. O'Connell 1404 S. Charles St

15 Filed ....., 19 Burial Permit Clerk, Registrar

R 3 01921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28/21

17 I HEREBY CERTIFY, That I attended deceased from 3/26/21, 19..., to 3/28/21, 19...,

that I last saw her alive on 3/28/21, 19...,

and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Exam.

(Signed) J. Edward Norris, M. D.

3/28, 19 21 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	3/31 1921
20 UNDERTAKER Margaret D. Flynn	ADDRESS 1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52452

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 W. Pratt ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia S. Arnold

(Residence in Baltimore: No. 1417 W. Pratt st St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 31 (Day), 1878 (Year)

7-AGE, 42 yrs. 8 mos. 2 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Corbin A Sank

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Julia Walsh

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr George W. Arnold

(Address) 1417 W. Pratt st

15-

Filed ....., 191.....

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MAR 30 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3/29/21 (Month) (Day) (Year), 191...

17- I HEREBY CERTIFY, That I attended deceased from August 1921, to March 29 1921, that I saw h-r alive on 3/29/21 191..., and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Stafford Dunn M. D.

3/29/21 191... (Address) 1417 W. Pratt St. Baltimore Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, April 1., 1921

20-UNDERTAKER James Digman & Son

ADDRESS 1000 S. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Armstrong)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52453 D 52453

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH St Josephs Hospital 9

CITY OF BALTIMORE: (No. ..... ST.: 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Armstrong

(a) RESIDENCE: NO. Lake Montebello, Hillen Road ST. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 9th 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7.	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James Warnstrong

11 BIRTHPLACE OF FATHER (city or town) Elsa
(State or country) Illinois

12 MAIDEN NAME OF MOTHER Abbie Richmond

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New Orleans

14 Informant James W. Armstrong
(Address) Lake Montebello Hillen Rd

15 Filed MAR 30 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1921 to March 30 1921
that I last saw him alive on March 30 1921
and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffi
ciency
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Emphysema - Right chest (duration) ..... yrs. ..... mos. Gunshot wound.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of March 20.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Schwenck M. D.

19 Address St Josephs Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 31st 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar Pneumonia

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52454 D 52454

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO. 117-09

CITY OF BALTIMORE: (No. ..... St.: 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Foley

(a) RESIDENCE. No. 1812 W. Pratt St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Foley

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant W. R. Scott

(Address) 812 W. Lombard St

15 Filed Robert P. Harrison, Registrar

R3 01921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 27, 1921, to March 30, 1921

that I last saw her alive on March 29, 1921

and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH* was as follows: over

General Peritonitis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy findings

(Signed) N. Goldsmith, M. D.

3/30/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Apr 1st 1921
20 UNDERTAKER John O. Mitchell	ADDRESS 1201 N. Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Streptococcus infection

Cause unknown

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52455

D 52455

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Francois,

(a) RESIDENCE. No. Preston Valley Hgts. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow o/-

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jean Francois,

6 DATE OF BIRTH (month, day, and year) Oct — 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alsace, France

PARENTS

10 NAME OF FATHER Louis Ernet

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Mary Cuney,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Sister Florence, (Address) Preston Valley Hgts.

15 Filed Mar 30 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

R 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1921

17 I HEREBY CERTIFY, That I attended deceased from to record, 19..., to ..., 19...,

that I last saw her alive on ..., 1921,

and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Warner, M. D.

Mar 30, 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peter's Cemetery	April 1 1921
20 UNDERTAKER	ADDRESS
F. A. Frances Son	739 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52456

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 Clifton ST.: 15 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Stiller

(a) RESIDENCE. No. 1749 Clifton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence Welch Stiller

6 DATE OF BIRTH (month, day, and year): April 18, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Robert Stiller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Robt O Stiller

(Address): 1749 Clifton Ave

15 Filed MAR 30 1921, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 30 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1919, to March 30, 1921, that I last saw h— alive on 3-27-, 1921, and that death occurred, on the date stated above, at 11 A m.

The ~~CAUSE~~ OF DEATH* was as follows:

Mitral Stenosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Thorough Physical Examination

(Signed) William Irvin Burgunt, M. D.

, 19 (Address) 1928 N Fulton Ave Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
National Cem	April 1st 1921

20 UNDERTAKER: Geo W Little ADDRESS: 2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52457

64 D 52457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 Saratoga St.: 19 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Gilmour

(a) RESIDENCE. No. 1814 Saratoga St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew M Gilmour

6 DATE OF BIRTH (month, day, and year) Aug 15 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos. Coughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lilly White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Andrew M. White

(Address) 1814 W. Saratoga St

15 Filed MAR 3 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to March 30, 1921, that I last saw her alive on March 29, 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy. (duration) yrs. few minutes mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Lamprid, M. D.

Mar 31 1921 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Apr 2 1921
20 UNDERTAKER	ADDRESS
Wm Tucker & Sons	Norfolk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52458

CERTIFICATE OF DEATH.

92 D 52458

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1019 S. Charles St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hartwig.

(a) RESIDENCE. No. 1019 S. Charles ST. St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? 53 yrs. 11 mos. 1 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie K. Hartwig.

6 DATE OF BIRTH (month, day, and year) April 29-1867.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	53	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman, 037

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City Fire Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jacob Hartwig.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Strohl.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Annie K. Hartwig. (wife)
(Address) 1019 S. Charles St.

15 Filed MAR 31 1921 ROBERT A KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1921

17 I HEREBY CERTIFY, That I attended deceased from March 29th., 1921, to March 30th., 1921, that I last saw him alive on March 30th., 1921, and that death occurred, on the date stated above, at 5.15 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

.....(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Apnoea.

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Otto F. Fernhardt, M. D.

March 30th. 1921. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Apr 2 1921

20 UNDERTAKER Mr. & Mrs. J. W. Tenfel & Son — ADDRESS 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52459 ✓ 137 D 52459

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2797 Alameda Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa E. Dorguth

(a) RESIDENCE. No. 2797 Alameda Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Otto Dorguth

6 DATE OF BIRTH (month, day, and year) May 19th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Paul Drobisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Heidrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Otto Dorguth
(Address) 2797 Alameda Ave.

15 MAR 31 1921 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to March 30, 1921.

that I last saw h.. alive on March 30, 1921.

and that death occurred, on the date stated above, at 6.15 a m.

The CAUSE OF DEATH* was as follows:

Puerperal- Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute appendicitis associated with Pregnancy (3 Mos)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 11 1921 (appendectomy)

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John G. Owens M. D.

March 30 1921 (Address) 8 E. Cor. Fremont & Mt Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 1. 1921

20 UNDERTAKER Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52460

CERTIFICATE OF DEATH.

175-004 D 52460

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 12 Eutaw Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Griffith

(Residence in Baltimore: No. 12 Eutaw Ave. Gardensville St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, April 3, 1915
(Month) (Day) (Year)

7-AGE, 5 yrs. 11 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Jesse Griffith

11-BIRTHPLACE OF FATHER (State or Country), Dayton Ohio

12-MAIDEN NAME OF MOTHER DeBoro F. Lenk

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse Griffith

(Address) 12 Eutaw Ave. Gardensville

15-

FILED MAR 31 1921 191... ROBERT I. KRAETER

Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 29, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Traumatism Cut by Automobile

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Kent Smiley M. D.
(Coroner)

3-29, 1921 (Address) Govans Md Rt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cem	Mar. 31, 1921
20-UNDERTAKER	ADDRESS
Mrs. Mrs John W. Tempel & Son	801 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71 D 52461

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 E. Chase St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Ott Roberts

(Residence in Baltimore: No. 1620 E. Chase St. 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Jan. 23, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Howard F. Roberts

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Ellen Holden

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. Howard Roberts

(Address) 1620 E. Chase St.

15- MAR 31 1921 ROBERT A KRAUSE 191.... Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH March 30th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 30th 1921, to March 30th 1921, that I saw her alive on March 30th 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

.....Pneumonia.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) E. E. Foutz M. D.

March 30, 1921. (Address) 1501 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	March 31, 1921
20-UNDERTAKER	ADDRESS
Henry Lutz	1007 N. Bond St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52462

CERTIFICATE OF DEATH.

91 D 52462

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 2019 E. Oliver ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blondine Howard

(Residence in Baltimore: No. 2019 E. Oliver St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 2 (Day) 1900 (Year)

7-AGE	If LESS than 1 day,
20 yrs. 9 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of Industry, business, or establishment in which employed (or employer): Md

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Howard

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Anita Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Hagerstown Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister

(Address) 2019 E. Oliver St

15- FILED MAR 31 1921, 191.... ROBERT A KRAUSE Registrar.

Burial Permit issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 12 1921, to March 29 1921, that I saw her alive on March 29 1921, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

B.

Broncho-pneumonia

(Duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. ds.

(Signed) W. R. Laycock M. D.

, 191... (Address) 2nt 3 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, April 1, 1921

20-UNDERTAKER Henry Lutz

ADDRESS 1007 N. Bond St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52463

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D 52463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 311 N. Payson (St.) 21 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Marks

(a) RESIDENCE. No. 311 N. Payson St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie L. Marks

6 DATE OF BIRTH (month, day, and year) Aug 4 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hatter

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Monticello A. A. Co. Maryland

PARENTS

10 NAME OF FATHER Henry Marks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Maryland

14 Informant Bessie L. Marks
(Address) 311 N. Payson St.

15 Filed MAR 31 1921 ROBERT S. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24th, 1921, to March 29th, 1921, that I last saw him alive on March 28th, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) one yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Helen F. Stillman, M. D.

March 30 1921 (Address) 1227 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 31 1921

20 UNDERTAKER Geo. R. Gerbig ADDRESS 2001 W. Baltimore St

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X157 ✓ D 52464

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Woods, south of Hanover St. bridge ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Denshuk.

(Residence in Baltimore: No. 15 S. Central Ave. St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, ... Do not know. (Month), 1 (Day), ... (Year)

7-AGE, 36 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Jakubk.

(Address) 224 N. Kenwood ave.

15- Filed MAR 31 1921 19.. Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Body found March 27th. 1921, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

Suicide by hanging.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

March 31 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	March 31 1921
20-UNDERTAKER	ADDRESS
Mc Fenson	Baltimore,

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52465

CERTIFICATE OF DEATH.

D 52465

Registered No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1145 N. Eden St.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Foote

(Residence in Baltimore: No. 1145 N. Eden St.; 6yr. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Col.	S

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 50+ yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9-BIRTHPLACE, (State or Country): born in Baltimore City

PARENTS.

10-NAME OF FATHER, Charles Foot

11-BIRTHPLACE OF FATHER (State or Country): born in Baltimore

12-MAIDEN NAME OF MOTHER Elizia Foot

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R A Elliott

(Address) 1726 Ashland Ave

15-

Filed MAR 31 1921, 191.....

ROBERT A ELLIOTT

Burial Permit Issued

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 28, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Hurt Guntley M. D.
(Coroner.)

3-28-1921 (Address) 19 E. Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lausal Cemetery	March 31 1921
20-UNDERTAKER	ADDRESS
Mrs R A Elliott	1726 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52466 ✓ D 52466

HEALTH DEPARTMENT—CITY OF BALTIMORE

103

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2518 E Madison (St.) (Ward) 7

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Elton

(a) RESIDENCE. No. 2518 E Madison St., Ward. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Marie P. Elton

6 DATE OF BIRTH (month, day, and year) Feby 17 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thomas R Elton

(Address) 2512 E Madison st

15 Filed MAR 31 1921 19 ROBERT A [illegible]

Registrar Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 13 1921, to March 15 1921, that I last saw him alive on March 15 1921, and that death occurred, on the date stated above, at 2.10 a m.

The CAUSE OF DEATH* was as follows: (Primary)

Acute Indigestion, 2 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E H Statt, M. D.

, 19 (Address) 35E Montgomery St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 31st 1921
20 UNDERTAKER	ADDRESS
George Schulting & Sons	1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Locke

D 52467

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52467

D 52467

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 55 Stanwellton av St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret M Locke

(Residence in Baltimore: No. 55 Stanwellton av St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	W	S

6-DATE OF BIRTH, Feb 21, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Donald J Locke

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret Whitson

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Donald Locke

(Address) 55 Stanwellton av

15-

Filed MAR 31 1921 ROBERT J. KRAUTH

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 21 1921, to March 30 1921, that I saw her alive on March 29 1921, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

General Debility due to
Premature Birth 7 months
Endo..... (Duration).....yrs. 1 mos. 9 ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration).....yrs. 1 mos. 9 ds.

(Signed) Jos. E. Sinex M. D.

March 30, 1921 (Address) 1520 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Mar 31, 1921

20-UNDERTAKER	ADDRESS
John J Fields	1202 W Fayette

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52468

Spec.—8-24-14—M. & T.—2000 Bks.

D 52468 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52468

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2639 Hampden Ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah A Thomasson

(Residence in Baltimore: No. 2639 Hampden Ave St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) Mch (Day) 1 (Year) .....

7-AGE 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Everett Speakes

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Martha Green

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. F. Thomasson

(Address) 2639 Hampden Ave

15- MAR 31 1921 Filed ....., 191.... ROBERT E KRAUTH Registrar. BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March (Month) 30th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 29 1921, to March 30 1921, that I saw h-r alive on March 30 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage .....

..... Complicated with pneumonia .....

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

March 31, 1921 (Address) 3543 Chesterfield Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Buck Hall Church Va | DATE OF BURIAL, ... April, 1921

20-UNDERTAKER A S Marshall | ADDRESS 3539 Fall Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52469

HEALTH DEPARTMENT—CITY OF BALTIMORE

168-001 D 52469

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1411 Warner St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John N.G. Warner. (C)

(Residence in Baltimore: No. 933 Argyle Ave.

34 ---------

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	Colored	Married.

6-DATE OF BIRTH, March 10th. 1863., 1
(Month) (Day) (Year)

7-AGE, 58 yrs. 0 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Talbott Co. Md.

PARENTS.

10-NAME OF FATHER, Lafayette Warner. (C)

11-BIRTHPLACE OF FATHER (State or Country), Talbott Co. Md.

12-MAIDEN NAME OF MOTHER Mary Littleton. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Talbott Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Warner. (C) wife.

(Address) 933 Argyle Ave.

15- Filed MAR 31 1921, 191 ROBERT I KRAUTZ Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 27th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. Autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental illuminating gas poisoning.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

March 29 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	March 31 1921
20-UNDERTAKER	ADDRESS
David Easton	916 Park ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

(Warring)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52470

CERTIFICATE OF DEATH.

D 52470

REGISTERED NO. C 794

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Brunt St ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. J. Warring

(Residence in Baltimore: No. 1711 Brunt St. St.; 35 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Blk	Married

6-DATE OF BIRTH, ... Jan. (Month) 15th (Day), 1871 (Year)

7-AGE,	If LESS than 1 day,
50 yrs. 2 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... waiter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Can't ascertain

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Can't ascertain

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matilda Warring

(Address) 1711 Brunt St

15- MAR 3 1921 ROBERT B KRAUTH

Filed ....., 19.. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 29th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 28th 1921, to March 29th 1921, that I saw him alive on March 29th 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

about

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis & Pulmonitis

(Duration) 1 yrs. 3 mos. ds.

(Signed) Dr. B. Glasscock M. D.

Mch 30th, 1921 (Address) 1529 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	April 1st, 1921
20-UNDERTAKER	ADDRESS
Clarence E. Wright	1361 W. Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

252471 Struck

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 252471

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Aliceanna ST.; 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon N. Strack

(a) RESIDENCE. No. 1608 Aliceanna ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 8/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER John Strack

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rue Campbell

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mrs Strack
(Address) 1608 Alice st.

15 Filed MAR 31 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 26 1921, to Mar 30, 1921

that I last saw h— alive on Mar 30, 1921

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stomach

2 (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. L. Campbell, M. D.

Mar 30 1921 (Address) 1644 N. Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	April 1 1921
20 UNDERTAKER	ADDRESS
Wm J. E. Evans & Son	1428 E. Chase St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Hamilton - 120 D 52472

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5706 Catalpa Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Suretta Moeller

(a) RESIDENCE. No. 5706 Catalpa Ave ST. Hamilton WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Kuss

6 DATE OF BIRTH (month, day, and year) March 20 1841

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Dr Carl Kahnmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emily Kuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Emily Kuss

14 Informant Mrs Albert Bell

(Address) 5706 Catalpa Ave

15 Filed MAR 31 1921 19 ROBERT I. KRAUSE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Mar 31, 1921, that I last saw h.. alive on Mar 30, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lungs

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Myocarditis & Interstitial Nephritis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas Strum, M. D.

Mar 31, 1921 (Address) 4706 Harper Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Phila Det Sepulchre	Mch 31 1921
20 UNDERTAKER	ADDRESS
Wm Cook	1745 Nor

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4r Druid Harford Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52473

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52473

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5225 Harford Road St.; 27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie F Van Reuth

(a) RESIDENCE. No. 5225 Harford Road St.; Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Belgium

PARENTS

10 NAME OF FATHER Edward C. H Van Reuth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Marie De Swart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Belgium

14 Informant Lucian Van Reuth

(Address) 5225 Harford Road.

15 Filed MAR 31 1921 ROBERT A KRAUTH Registrar

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1921

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1920, to Mar 30, 1921,

that I last saw h[illegible] alive on Mar 29, 1921,

and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Sigmoid Colon

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 15?

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Chas Emerson, M. D.

March 31, 1921 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	4/1 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E Nash

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52474

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

D 52474

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 S. Chester ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Myers

(Residence in Baltimore: No. 104 S. Chester St. 39 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Mar (Month) 2 (Day) 1881 (Year)

7-AGE: 39 yrs. 4 mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Balto. Md

PARENTS

10-NAME OF FATHER: Frederick G Schiller

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Mary Ezzle

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H Myers

(Address) 104 S Chester St

15- MAR 31 1921 ROBERT P. BRAUER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 30th (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec, 1920, to, March 1921, that I saw h.. alive on March 30th 1921, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) about 2 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) H. J. Jenkins M. D.

3/30 1921 [Address] 1197 N. Milton Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: March 1921

20-UNDERTAKER: W. E. Bad — ADDRESS: 502 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 9 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Mechling

(a) RESIDENCE. No. 2721 Fraley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Mechling

6 DATE OF BIRTH (month, day, and year) Jan 24 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Asylano Conn.

PARENTS

10 NAME OF FATHER Jos Mechling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Cath Amund

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ashland Conn

14 Informant Mary E. Mechling (Address) 2721 Fraley St

15 Filed MAR 31 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28/1921

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1921, to March 28, 1921, that I last saw him alive on March 28, 1921, and that death occurred, on the date stated above, at 11.30A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Symptoms & Physical Signs

(Signed) Chas. O'Donovan, M. D.

, 19 (Address) 5. E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 1 1921
20 UNDERTAKER	ADDRESS
Ed A Weidefeld	5. 22 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52476

CERTIFICATE OF DEATH.

92

D 52476

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 Fremont Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lambert Roche

(a) RESIDENCE. No. 735 Fremont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Roche

6 DATE OF BIRTH (month, day, and year) August 25th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	47	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Express Business

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo J. Roche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mamie Roche (Address) 735 Fremont ave

15 Filed MAR 31 1921 19 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) March 27th 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 27th, 19 21, to March 27th, 19 21, that I last saw h[illegible] alive on March 27th, 19 21, and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Labor Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo Illegible M D, M. D.

March 27th, 19 21 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	April 1921
20 UNDERTAKER E. A. Winfield Jr	ADDRESS 501 E 22

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52477

CERTIFICATE OF DEATH.

D 52477

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 N. Dallas ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna Lohman.

(Residence in Baltimore: No. 1823 N. Dallas st. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Feb 22, 1861 (Month) (Day) (Year)

7-AGE, 60 yrs. 1 mos. 6 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Peter Brown

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. Walters.

(Address) 1825 N. Dallas st

15- MAR 31 1921 Filed ..... 191.. ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 28, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 10 1921, to Mar 28 1921, that I saw her alive on Mar 27 1921, and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

1 Mitral Regurgitation

.....

.....

(Duration) 2 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Heart Disease

(Duration) .... yrs. .... mos. .... ds.

(Signed) E. E. Brunt M. D.

Mar 28 1921 (Address) 1531 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore County — DATE OF BURIAL, April 1, 1921

20-UNDERTAKER George J. Ruth — ADDRESS 1735 Hanford Av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52478 HEALTH DEPARTMENT--CITY OF BALTIMORE D 52478

CERTIFICATE OF DEATH

402

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 2311 Edmondson St.: 16 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry W. Klein

(Residence in Baltimore: No. 2311 Edmondson. St.: 63 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH: Mr 29, 1857 (Month) (Day) (Year)

7-AGE: 63 yrs. 3 mos. 29 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Grocery

9-BIRTHPLACE (State or country): Balto Md.

PARENTS

10-NAME OF FATHER: Gustav Klein

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: C Lehring

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Eliza V Klein

(Address) 2311 Edmondson

15. MAR 31 1921 [91] ROBERT J KRAUTH Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Mar. 28, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1921, to, Feb. 28 1921, that I saw him alive on Feb. 28, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) Epithelioma.

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Herbert E Blake M. D.

Mar 30, 1921 (Address) 1614 W Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: March 31, 1921

20-UNDERTAKER: W M Lowthorn

ADDRESS: 2238 N Howard

Spec.—6-9-19—H. P. Co.— 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52479

28 D 52479

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 S.BrOadway ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur John Pritchard Brenton

(a) RESIDENCE. No. 2 S.Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13.1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Office clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 669

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John S.Brenton

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella C.McComas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Parlett Brenton
(Address) 2 S.Broadway

15 Filed MAR 31 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1920, to March 29th, 1921, that I last saw him alive on March 29th, 1921, and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

Generalized Tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (Bilateral)

(duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death? France.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Michael A. Abrahms M.D., M. D.

, 19 (Address) 2360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Arl 1 1921
20 UNDERTAKER	ADDRESS
Milton W.Jones	424 N.Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D 52480

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1029 N. Stricker ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Gruber

(Residence in Baltimore: No. 1029 N. Stricker St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, November, 27, 1856
(Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, John H. Gruber

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Charlotte Bretzy

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. G. Gruber

(Address) 2222 N. Northern

15- MAR 31 1921 Filed....., 191.... ROBERT J. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
5 minutes
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old Age
(Duration) yrs. mos. ds.

(Signed) J. D. Hennessey M. D.
(Coroner.)

March 27, 1921 (Address) 2807 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pleasant Grove, Balto Co Md	April, 1921
20-UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52481

HEALTH DEPARTMENT—CITY OF BALTIMORE

52481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3803 Dorchester Road ST.: 15 WARD) 94

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Margaret Sauer

(a) RESIDENCE. NO. 3803 Dorchester Road ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? 77 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Sauer

6 DATE OF BIRTH (month, day, and year) Oct. 15" 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mathais Romoser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Mrs. William P. Gildea

(Address) 3803 Dorchester Road

15 Filed MAR 31 1921 ROBERT E. FRANCIS Registrar of Vital Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1921

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1921, to March 29, 1921, that I last saw her alive on March 28, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Senile debility - 5 days

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. F. Smith, M. D.

3-30. 1921 (Address) 118 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Mar 31" 21
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N Calvert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52482

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hospital ST.: 9175-001 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert R. Strasburg

(Residence in Baltimore: No. 510 E. 35th St. St.) 8 yrs., 3 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, December 11th, 1913.
(Month) (Day) (Year)

7-AGE, 8 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Reese A. Strasburg

11-BIRTHPLACE OF FATHER (State or Country), Staunton, Va.

12-MAIDEN NAME OF MOTHER Rosa Kroeder

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Geo. W. Houck

(Address) 2541 N. St Paul St.

15-

Filed ....., 191.... [illegible] Registrar.

MAR 31 1921

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 29th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) ...find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Left [illegible]

[illegible]

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner.)

3-29-, 191., (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Mar 31st, 1921

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bal. St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52483 ✓

D 52483

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 E. Eager ST.: 10 WARD)

2-FULL NAME Henrietta Habblett

(a) RESIDENCE. No. 1101 E Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Fred Nolle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Johannason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Stadelmeier
(Address) 2012 E. Lafayette ave

15 MAR 31 1921 Burial Permit Issued [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1921

17 I HEREBY CERTIFY, That I attended deceased from March 25 1921, to March 25 1921, that I last saw her alive on March 25 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) John C. T. Arey, M. D.

, 19 (Address) 1603 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 5 1921
20 UNDERTAKER	ADDRESS
Mrs Johannah Canoles	946 Aisquith St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52484 — CERTIFICATE OF DEATH. — D 52484

t-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis ST.: [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Fairley

(a) RESIDENCE. NO. 502 Pearl ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina.

PARENTS

10 NAME OF FATHER Abe Steel

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina.

12 MAIDEN NAME OF MOTHER Mona Malvis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina.

14 Informant

(Address)

15 Filed [illegible] 19 Registrar

MAR 31 1921 Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 8, 1920, to March 27, 1921,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of —

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) L. J. Argyy, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAR 30 1921

20 UNDERTAKER

ADDRESS

Commissioner Health.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52485 HEALTH DEPARTMENT—CITY OF BALTIMORE

X 30 D 52485

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Davis.

(a) RESIDENCE. No. Unknown ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennesse

PARENTS

10 NAME OF FATHER Edward Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennesse

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed MAR 31 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24., 1921 to March 27, 1921, that I last saw him alive on March 27, 1921, and that death occurred, on the date stated above, at 3:15 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No especial test.

(Signed) B. Heyman, M. D.

3/28/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: MAR 30 1921

20 UNDERTAKER: Commissioner Health, — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 52486 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52486

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Butcher

(a) RESIDENCE. No. 1412 High Alley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harper Ferry, Virginia

PARENTS

10 NAME OF FATHER Thomas Butcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records, New City Hospital.

15 MAR 31 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to March 26, 1921, that I last saw him alive on March 25, 1921, and that death occurred, on the date stated above, at 9 A.M. a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.
(No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No special test.

(Signed) Patterman, M. D.

3-26-1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	MAR 30 1921
20 UNDERTAKER ADDRESS Commissioner Health.	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 52487

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52487

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. ... WARD)

2-FULL NAME Baby Broughton

(a) RESIDENCE. No. 2519 E. Monument St ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 25-1921

7 AGE	Years	Months	Days	If LESS than 1 day, 23 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Howard L. Broughton

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Va

12 MAIDEN NAME OF MOTHER Josephine L. Chartish

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) N. Y.

14 Informant ...
(Address) ...

15 Filed ..., 19 ... Registrar

Robert F. Garrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/ 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1921, to March 26, 1921, that I last saw her alive on March 26, 1921, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) C. C. French, M. D.

, 19 (Address) Lawndale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAR 30 1921 19

20 UNDERTAKER Commissioner Health,

ADDRESS

Per. WM. R. WOODALL

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52488

52488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 108

CITY OF BALTIMORE: (No. Beidler & Silmans Aspen St. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Leisure

(a) RESIDENCE. No. 539 E. Fort Ave. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie J. Leisure

6 DATE OF BIRTH (month, day, and year) Oct 31st 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Leisure

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Susan Spurrier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Jennie J. Leisure
(Address) 539 E Fort Ave

15 Filed MAR 31 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/23, 1921, to 3/30, 1921, that I last saw h. in alive on 3/30, 1921, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of appendix 3/23/21

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory + autopsy

(Signed) O Lilio S. Fowler, M. D.

3/30, 1921 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 2 1921
20 UNDERTAKER	ADDRESS
B Schloman & Son	Removed

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acute Appendicitis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52489

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 575 N Charles ST. 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Maria L de Vessey

(a) RESIDENCE. No. 575 N Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of T. A. Tow Haffner

6 DATE OF BIRTH (month, day, and year) 7/10/49

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired M.D.

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER J. M. B. Terrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliz C. Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Louise Dey Haffner

(Address) 575 N Charles St

15 Filed MAR 31 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29th 1921

17

I HEREBY CERTIFY, That I attended deceased from March 18th, 1921, to March 29th, 1921, that I last saw h alive on March 29th, 1921, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation with Acute Cardiac Dilatation.

(duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar D. Perkins, M. D.

, 19 (Address) 1 W Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4/ 1921
20 UNDERTAKER	ADDRESS
Wm H Edwards Sons	1318 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 52490

CERTIFICATE OF DEATH

92-010 D 52490

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. N.E.C. Mondawmin & Dennison Sts. 15 WARD).

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frances Sanderson

(Residence in Baltimore: No N. E. Cor. Mondawmin & Dennison St.; 70 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May 1, 1844 (Month) (Day) (Year)

7 AGE: 76 yrs. 7 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Journalist
(b) General nature of industry, business, or establishment in which employed (or employer): 08

9 BIRTHPLACE (State or country): Fredrick Md

PARENTS

10 NAME OF FATHER: Thomas Sanderson

11 BIRTHPLACE OF FATHER (State or country): Fredrick

12 MAIDEN NAME OF MOTHER: Hannah Ann Pearson

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. A. Sanderson

(Address) Mondawmin & Dennison Sts

15 Robert E. Harrison, Filed ..... 191 ..... REGISTRAR

MAR 31 1921

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 29, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1", 1921, to March 29 1921, that I saw him alive on March 29", 1921, and that death occurred, on the date stated above, at 11:50 A. m.
The CAUSE OF DEATH* was as follows:

Septicemia and Boil on Pneumonia

..... (Duration) ..... yrs. ..... mos. 20 ds

Contributory (SECONDARY) Cardiac Asthenia

..... (Duration) ..... yrs. ..... mos. 9 ds.

(Signed) Herbert E. Lapt M. D.

March 31", 1921. (Address) 3050 A. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cem — DATE OF BURIAL: April 1st, 1921

20 UNDERTAKER: John C. Mitchell — ADDRESS: 201 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

14768

D 52491

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 D 52491

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helio Nieto

(a) RESIDENCE. No. 2208 East North ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Nieto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Martina Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant Hospital Records
(Address)

15 FILED MAR 31 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1921, to March 30, 1921, that I last saw him alive on March 30, 1921, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) W Harrison, M. D.

3-31-1921 (Address) J H Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Apl 1 1921

20 UNDERTAKER Clark & Sumwalt Bro

ADDRESS 1822 N Bway

MAR 31 1921

MAR 31 1921

MAR 31 1921

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"): *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Otitis media prior
& erysipelas

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52492

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52492

CERTIFICATE OF DEATH.

X137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital St. 11 - WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bessie Smith

(a) RESIDENCE. NO. Westminster, Md. WARD. Westminster Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Smith

6 DATE OF BIRTH (month, day, and year) Jan. 28 [redacted] 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Father Wimsil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mh Sharffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William Smith

(Address) Westminster Md

15 Filed Robert P. Harrison, Registrar

R3 1 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 / 1921

17

I HEREBY CERTIFY, That I attended deceased from March 17 / 1921, to March 31, 1921, that I last saw her alive on March 31 — 1921, and that death occurred, on the date stated above, at 1.280 p. m.

The CAUSE OF DEATH* was as follows:

Puerperal Infect—
Puerperal Insanity

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Westminster, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Philibert Antigiani, M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Linders Cem. Westminster	Apr 3 1921
20 UNDERTAKER	ADDRESS
H Bankard & Son	Westminster

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] is very important. See instructions on back of certificates.

(Meads)

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 52493

CERTIFICATE OF DEATH

D 52493

170

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 5306 York Road St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. K. Meads

(Residence in Baltimore: No. 5306 York Road St.; 3 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F.

4-COLOR OR RACE: W.

5-~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: May 14 (Month) (Day), 1852 (Year)

7-AGE: 68 yrs. 10 mos. 16 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE (State or country): Maryland Line Md.

PARENTS

10-NAME OF FATHER: Thos. G. Rutledge

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Rebecca J. Fife

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos. J. Meads

(Address) 5306 York Road

15- Robert P. Harrison,

FILED MAR 31 1921, 191 ..... REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 30 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to, Mar. 30 1921, that I saw her alive on Mar. 30 1921, and that death occurred, on the date stated above, at 11-30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) — yrs 2 mos — ds.

Contributory (SECONDARY) Chronic Brights Disease

(Duration) 7 yrs 6 mos — ds.

(Signed), J. Poyntz Carter M.D.

Mar. 30 1921 [Address] Towson Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Maryland Line Md. DATE OF BURIAL: Apr [redacted] 1921

20-UNDERTAKER: Bertrand Bros. ADDRESS: 1229 N. Lafayette Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52494

HEALTH DEPARTMENT—CITY OF BALTIMORE

91

D 52494

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John's Hopkins Hos ST.: V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Novak

(a) RESIDENCE. No. 312 S. Regester ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 03 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 7 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Pete Novak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Wakonski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Peter Novak

(Address) 312 S Regester St

15 Filed MAR 31 1921 Robert P. Harrison, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 30, 1921, to Mar 30, 1921, that I last saw her alive on Mar. 30, 1921, and that death occurred, on the date stated above, at 3.45 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. H. Davison, M. D.

, 19 (Address) 1 H H Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 1 1921
20 UNDERTAKER	ADDRESS
John H Weber	1893 Bank

should be stated EXACTLY. PHYSICIANS should state
it may be properly classified. Exact statement of OCCUPA-
on back of certificates.
mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that
TION is very important. See instructions

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history of any other infection prior. Only at hospt. 1 hr. before death.

Spec.—6-9-19—H. P. Co.—1000 Bks. See affadavit over

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52495

CERTIFICATE OF DEATH.

170 D 52495

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dunn

(a) RESIDENCE. No. Baltimore & Schroeder ST.S WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~57~~	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER John Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed Robert F. Harrison, Registrar

MAR 31 1921

Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1921, to March 30, 1921, that I last saw him alive on March 30, 1921, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis. (No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) [signature] M. D.

3-31-1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Apr. 2 1921

20 UNDERTAKER E. V. Fanning & Son ADDRESS 1460 Battery Av

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEPARTMENT OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

LAMAR HOLLYDAY,
SUPERINTENDENT
W. H. CURRY,
PURVEYOR

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

5249

BAY VIEW HOSPITAL
HIGHLANDTOWN P. O.

April 28,1921

To Whom It May Concern:-

In a death certificate of John Dunn, who died at this hospital March 30,1921 his age was given as fifty-seven years Mr. Michael H. Noon who had known this man for many years to-day informs me that the correct age is seventy-five.

N.B. Herman
Resident Physician.

NBH/LH.

Subscribed. &. Sworn to This Date. 4/28/1921

Thomas J Daly
Notary Public

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52496

D 52496

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 E. Ostend St. 23 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgianna Spencer

(a) RESIDENCE. No. 7 E. Ostend St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none. old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Wm. Durham.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Mary Bristow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Maggie Delany.

(Address) 1441 Henry St.

15 MAR 31 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1921

17

I HEREBY CERTIFY, That I attended deceased from 9-9-20, 19..., to 3/30, 1921, that I last saw her alive on 3/30, 1921, and that death occurred, on the date stated above, at 11. a. m.

The CAUSE OF DEATH* was as follows:

Anemia.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (9-9-20) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) O Lilips Lowber, M. D.

3/31, 1921 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Hill.	April 2 1921

20 UNDERTAKER E J Manning H & Burial Co.

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52497

64

D 52497

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2703 Guilford ave ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rodolph A Butterfield

(a) RESIDENCE. No. 2703 Guilford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E Butterfield

6 DATE OF BIRTH (month, day, and year) Jan 12-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Indies

PARENTS

10 NAME OF FATHER Nathaniel G Butterfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Lonsbrun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary E Butterfield
(Address) 2703 Guilford ave

15 Filed ....., 19 .....

Registrar

MAR 31 1921

Robert P. Harris

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1921, to Nov 29, 1921, that I last saw him alive on Nov 29, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Senile nephritis Causing uraemia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bact & Lab. examn.

(Signed) G. G. Finke M. D.

, 19 (Address) 1201 N. Chas. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Apr 1 1924
20 UNDERTAKER J. A. Doran	ADDRESS 3000 E Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52498

CERTIFICATE OF DEATH.

120 D 52498

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 S. Ellwood Av. ST. 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Moran

(a) RESIDENCE. NO. 814 S. Ellwood Av ST. 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Charles Moran
(Address) 814 S Ellwood ave

15 Filed MAR 31 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1919, to March 28, 1921, that I last saw h.. alive on March 26, 1921, and that death occurred, on the date stated above, at 8. a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) M. J. McAvoy, M. D.

3/31, 1921 (Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	4/1 1921
20 UNDERTAKER J. A. Moran	ADDRESS 300 E Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Fowble)

D 52499 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52499

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Francis & Whitelock St.: 13 Ward) REGISTERED No. C 29

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard R. Fowble

(Residence in Baltimore: No. 1555 - Clifton ave St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 25, 1883
(Month) (Day) (Year)

7-AGE, 37 yrs. 3 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Henry Fowble

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth Wilhelm

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno H. Fowble

(Address) 1555 Clifton ave

15-

Filed Mar 31, 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D. (Coroner)

Mar 31, 1921 (Address) 1432 Rolandave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pleasant Hill — DATE OF BURIAL, Apr 2, 1921.

20-UNDERTAKER E. L. Roy Stiffler — ADDRESS 125 E North ave

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 31 1921

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52500

CERTIFICATE OF DEATH.

79

D 52500

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 517 W. Biddle ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aiatella Miller

(Residence in Baltimore: No. The Shelter (517 W. Biddle St.; ....yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	Col	Widow

6-DATE OF BIRTH, ..., 1 1843
(Month) (Day) (Year)

7-AGE, 78 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (Domestic) 01
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matron The Shelter

(Address) 517 W. Biddle St.

15- Filed APR 1 - 1921, 191... ROBERT J. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 191..., to March 28 1921, that I saw h.. alive on March 28 191..., and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Chronic Nephritis

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

....., 191... (Address) 1316 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence The Shelter 517 W. Biddle St.

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, April 1 or 2, 191...

20-UNDERTAKER Chas. E. Franck ADDRESS 804 Madison ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52501

CERTIFICATE OF DEATH.

15 D 52501

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Melvale, Md ST.; 37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Infant) Randall

(Residence in Baltimore: No. Melvale Md St.; —yrs., —mos. 4 ds.)

N. B.—Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 27, 1921 (Month) (Day) (Year)

7-AGE, — yrs. — mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Melvale, Md.

PARENTS.

10-NAME OF FATHER, Blanchard Randall Jr.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Roxaine McElvaine

13-BIRTHPLACE OF MOTHER (State or Country), Chicago, Ill.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin Tappan M.D.

(Address) 1102 North Charles St.

15- APR 1 - 1921 ROBERT F. KRAUSE

Filed....., 191.... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 27 1921, to March 31 1921, that I saw h[illegible] alive on March 31 1921, and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

(Signed) Benjamin Tappan M. D.

Mar 30..., 1921 (Address) 1102 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery DATE OF BURIAL, April ..., 1921

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52502

CERTIFICATE OF DEATH

151 D 52502

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Union Ave + Georgetown Road ST.; 26 WARD)

2-FULL NAME Hilda Mabel Starsoneck

(Residence in Baltimore: No. Union Ave + Georgetown Rd St.; ..... yrs. ..... mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Child

6-DATE OF BIRTH: Mch (Month) 26 (Day), 1921 (Year)

7-AGE: — yrs. — mos. 5 ds.

If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Balto Md.

PARENTS

10-NAME OF FATHER: Richard Starsoneck

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Hilda Herald

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Starsoneck

(Address) Union ave + Georgetown Road

15- Filed APR 1 - 1921 ROBERT J. KRAUTH Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Mch (Month) 31 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 26, 1921, to Mch 31 1921.

that I saw her alive on Mch 30, 1921.

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. 7 mos. ..... ds

Contributory (SECONDARY) same

(Duration) ..... yrs. 7 mos. ..... ds.

(Signed) Herbert Kieffer M. D.

Mch 31, 1921. (Address) Monument & Bond Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery

DATE OF BURIAL: April 1 1921

20-UNDERTAKER: Harry H. Weitz Inc

ADDRESS: 1531 W Lombard St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52503

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Urbas

(a) RESIDENCE. NO. 832 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of nakow

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John Chester

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Anton Urbas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Helen Naujal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithaunia

14 Informant J. [redacted] Urbas

(Address) 832 Hollins St

15 Filed APRI-1921 19 [redacted] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1921

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to March 31, 1921, that I last saw him alive on March 31, 1921, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY Chronic Valvular Heart Disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronushas, M. D.

3-31-21 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 4 1921
20 UNDERTAKER	ADDRESS
John Grebliunas	425 S. Pac

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52504

CERTIFICATE OF DEATH.

18

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 S. Calhoun ST.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Louis Wain

(a) RESIDENCE. No. 114 S. Calhoun ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15th 1920

7 AGE — Years: — Months: 3 — Days: 17 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Elmer Wain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Pearl Lohr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Elmer Wain

(Address) 114 S. Calhoun St.

15 Filed APR 1 - 1921 ROBERT F. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/24/21, 19..., to 4/1/21, 19..., that I last saw h... in alive on 3/31/21, 19..., and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) ... yrs. ... mos. 7 ... ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) F. Wm. Lee, M. D.

, 19 (Address) 1302 Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Apr 2nd 1921
20 UNDERTAKER	ADDRESS
Philip Hennig	2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52505

CERTIFICATE OF DEATH.

D 52505

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 748 W Hamburg ST.: 21 WARD)

2-FULL NAME Infant Cossup

(a) RESIDENCE. NO. 748 W Hamburg ST., WARD. 21

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 30-21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER A Cossup

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER M Yosh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant A Cossup

(Address) 748 W Hamburg St

15 Filed APRIL 1921 19 ROBERT A KRAUSE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 30 19 21, to Mar 31, 19 21.

that I last saw him alive on Mar 31, 19 21.

and that death occurred, on the date stated above, at 2-30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm S Schwaneke, M. D.

, 19 (Address) 1200 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52506

CERTIFICATE OF DEATH.

64 D 52506

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Bolton ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Diadema S. Scarlett

(a) RESIDENCE. No. 1717 Bolton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. W. Scarlett

6 DATE OF BIRTH (month, day, and year) March 3, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Blackwood, N. J.

PARENTS

10 NAME OF FATHER John Hider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Blackwood N. J.

12 MAIDEN NAME OF MOTHER Mary Cheesman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lower Lynn N. J.

14 Informant Clarence E. Scarlett

(Address) 1717 Bolton St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1921

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to March 31, 1921, that I last saw h.r alive on March 31, 1921, and that death occurred, on the date stated above, at 10, P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) M. E. O'Neill M. D.

4/1, 1921 (Address) 108 N. Bolton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Blackwood N. J.	Apr 9 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E. North

APR 1 1921

APR 1 1921

Burial Permit Issued

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Minnie Heiser)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52507

CERTIFICATE OF DEATH.

15 D 52507

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 Rutland ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Heiser

(a) RESIDENCE. No. 1018 Rutland a ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant L Lucas Jr Jane (Address) 1018 Rutland Ave

15 Filed APR 1 - 1921 19 [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 19 21

17

I HEREBY CERTIFY, That I attended deceased from Mar 29, 19 21, to Mar 30, 19 21, that I last saw h[illegible] alive on Mar 30, 19 21, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Old age - Anemia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Extreme Debility

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Evan W White M. D.

3/31. 1921 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westernpenitentiary Dr	Apl 2 1921
20 UNDERTAKER Robt J Turner	ADDRESS 1442 N Mon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52503

CERTIFICATE OF DEATH.

153 D 52503

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2811 Reese St. WARD) 9

2-FULL NAME Geraldine Sullivan

(Residence in Baltimore: No. 2811 Reese St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.)
Female	white	Baby

6-DATE OF BIRTH, ... Feb. (Month) 1 (Day) 1921 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John J Sullivan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Emelius

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Sullivan

(Address) 2811 Reese St

15-

APR 1 - 1921, 191.... ROBERT J. [illegible] Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Mar. (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jack of care

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) M. D.

3-31-1921 (Address) ..... St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Apr. 1, 19 21
20-UNDERTAKER Clark J Turner	ADDRESS 1x x 2 St Paul

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52509

CERTIFICATE OF DEATH.

64 D 52509

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 Eutaw Place ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Rebecca Brundige Mister.

(a) RESIDENCE. No. 1931 Eutaw Place. ST., 14 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? 69 yrs. 6 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Beverly W. Mister.

6 DATE OF BIRTH (month, day, and year) Sept-15-1851.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER Thomas V. Brundige

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Margaret W. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co, Maryland

14 Informant (Address): George T. Mister (son) Tudor Hall Apts., City.

15 Filed APR 1 - 1921 ROBERT J. KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1912 to March 30, 1912

that I last saw h[e]r alive on March 30 4 P 12

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (hour)
Apoplexy (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard Bruchen, M. D.

Mar X, 19 21 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Apr-2-21 19
20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS: 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52510 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52510

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 522 S. Washington St. ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry James

(Residence in Baltimore: No. 522 S. Washington St. 55 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 16 (Day) 1841 / (Year)

7-AGE, 79 yrs. 10 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry James

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fredrick James

(Address) 522 S. Washington st.

15- Filed APR 1 - 1921, 191.. ROBERT J. KRAUTH Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 31 (Day) 1921 (Year), 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....apoplexy.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Edward Gus Custer M. D.
(Coroner)

3/31/21, 191.. (Address) 800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetary

DATE OF BURIAL, April 2, 1921

20-UNDERTAKER H. Sanders & Son

ADDRESS 1710 Fleet St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D 52511 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52511

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 20 N. Curley St. 6 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Marston
(Residence in Baltimore: No. 20 N Curley St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: Col.
5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, April 30, 1875
(Month) (Day) (Year)

7-AGE, 46 yrs. 11 mos. 0 ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Producer Hauler
(b) General nature of industry, business, or establishment in which employed (or employer): Q45

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.
10-NAME OF FATHER, Albt E. Worsham
11-BIRTHPLACE OF FATHER (State or Country), Baltimore
12-MAIDEN NAME OF MOTHER, Mary E. Parker
13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ella V. Worsham
(Address) 20 N. Curley St.

15- Filed APR 1 - 1921, 191. ROBERT J. KRAUSE, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Cystitis & Stone in Kidney
(Duration) ....yrs....mos....ds.
CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.
(Signed) H. Smith Mosley M. D.
(Coroner)
4-30, 1921. (Address) 29 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery
DATE OF BURIAL, April 1, 1921.
20-UNDERTAKER H. Sander's Sons
ADDRESS 710 Fleet St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52512 ✓ D 52512

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brown

(a) RESIDENCE. NO. St Agnes Hospital ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74	"	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Do not know
(State or country)

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) " Do not know

14 Informant Mary Brown
(Address) St Agnes Hosp

15 Filed APR 1 - 1921, 19.... [illegible]
Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31 1921

17 I HEREBY CERTIFY, That I attended deceased from 9-29, 19 21, to 3-31, 19 21,
that I last saw h alive on 3-31, 19 21,
and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis - chronic
Intestinal obstruction

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-3-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Welch, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	4/1/21
20 UNDERTAKER	ADDRESS
M. Fahey & Son	1807 W Mts

CAUSE should be stated EXACTLY. PHYSICIANS should state
mation should be carefully supplied. AGE should be stated
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52513 ✓

D 52513

CERTIFICATE OF DEATH.

X 79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alice Beam

(a) RESIDENCE. No. Edmonds, Md. ST., ... WARD. Edmonds Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. / ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/10/52

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) House Keeper.

(c) Name of employer F. Dugan.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Beam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anne Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. F. Dugan

(Address) Edmondsville Md

15 Filed APR 1 - 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 19 21

17 I HEREBY CERTIFY, That I attended deceased from 3/20, 19 21, to 3/20, 19 21, that I last saw h alive on 3/20, 19 21, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Several yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arter. Card. Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lewis D. Pickett, M. D.

3/21, 19 21 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount.	3/23/21
20 UNDERTAKER	ADDRESS
W. Fackey & Sons.	1827 N. Gay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52514

CERTIFICATE OF DEATH.

D 52514

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (NO. Fort McHenry Baltimore Md ST.: 24 WARD) X 109

2-FULL NAME Everett D Kendall

(a) RESIDENCE. NO. US. Public Health Hosp. #56 St. Fort McH WARD. Baltimore Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
21 yrs.	--	-----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) New Hampshire

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Kraebel Registrar
(Address) US. PHS Hosp #56 Ft McHenry Md.

15 Filed APR 1 - 1921 ROBERT J. KRAUSE Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to March 30, 1921, that I last saw him alive on March 30, 1921, and that death occurred, on the date stated above, at 12'00 p.m.

The CAUSE OF DEATH* was as follows:

Hernia femoral & acute dilitation cardiac.

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of March 30 1921

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) Thomas A. Payne M. D.
Senior Surgeon (R)

, 19 (Address) US. PHS hosp. #56 Ft Mchenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Field N. H.

DATE OF BURIAL April 1, 1921

20 UNDERTAKER L. Johnson & Bro

ADDRESS 1127 E Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52515 D 52515 D 52515 D 52515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John's Pleasant Rest St.; 19 WARD)

2-FULL NAME Roy Wellman

(a) RESIDENCE. No. Lutherville rub. ST., WARD. Lutherville Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3 wks.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record
(Address) J. H. H.

15 Filed APR 1 - 1921 19.. ROBERT I. KRAUTH Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1st 1921, to March 31 1921, that I last saw h.. alive on March 31 1921, and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Spina Bifida

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) Meningitis Secondary

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) W. R. Davis, M. D.

Apl 1, 1921 (Address) 1 W B Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
John's Pleasant Rest Lem	April 1st

20 UNDERTAKER John Burns Sons ADDRESS Towson

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52516

CERTIFICATE OF DEATH.

1920 D 52516

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St.: 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Agnes Leonard

(a) RESIDENCE. No. 1610 Cole St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 31 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55 yrs.		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Galt, Ont

PARENTS

10 NAME OF FATHER Samuel Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Mary Lord

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mrs Agnes Hospital (Address) 1610 Cole St

15 Filed APR 1 - 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1 1921

17

I HEREBY CERTIFY, That I attended deceased from 3-25, 1921, to 4-1, 1921,

that I last saw h[illegible] alive on 4-1, 1921,

and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

Nephritis - chronic.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis - chronic.

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. McCraig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 4 1921

20 UNDERTAKER John J Fields ADDRESS 1200 W Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52517

CERTIFICATE OF DEATH.

151 D 52517

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 55 S. Canwell Av ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin J. Locke

(Residence in Baltimore: No. 55 S. Canwell Av St.; ..... yrs., 1 mos. 7 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb 21, 1921.
(Month) (Day) (Year)

7-AGE, — yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Donald J. Locke

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Margaret E. Holborn

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Donald J. Locke

(Address) 55 S. Canwell Av.

15- APR 1 - 1921 ROBERT B. KRAUTH

Filed....., 191.... Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 21 1921, to Apr 1 1921, that I saw him alive on Apr 1 1921, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as followa:

General Debility due to Premature Birth

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Joseph S. Mills M. D.

Apr 1, 1921. (Address) 15-20 Hamilton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Apr 3, 191...
20-UNDERTAKER	**ADDRESS**
John J. Fields	1200 N. Gonbard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52518

D 52518

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Batchelor

(a) RESIDENCE. No. 506 Riverside Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 28 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Batchelor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Minnie Kunze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Wm P Burns

(Address) 526 Riversidave

15 Filed APR 1 1921, 19 Robert T. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/ 1921

17

I HEREBY CERTIFY, That I attended deceased from 3/31/21, 1921, to 3/31/21, 19....., that I last saw h.im alive on 3/31/21, 19....., and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Int. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs Symptoms.

(Signed) Claus A Jansen, M. D.

, 19 (Address) 5. E. Read.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Apr 2 1921
20 UNDERTAKER Margaret L. Flynn	ADDRESS 1422 Light St

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52519 ✓

138

D 52519

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Genl. Hospital ST.: 13 WARD)

2-FULL NAME Mrs Etta R. Adams.

(a) RESIDENCE. NO. 3432 Roland Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of ~~HUSBAND of~~ William F Adams

6 DATE OF BIRTH (month, day, and year) Nov 22 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Samuel Redlick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Jane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant (Address) Wm F Adams 3432 Roland Ave

15 Filed APR 1 - 1921 Robert P. Harrison, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1921, to April 1, 1921, that I last saw h.e alive on April 1, 1921, and that death occurred, on the date stated above, at 2 15 a.m.

The CAUSE OF DEATH* was as follows:

Pregnancy.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Mar. 30. 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical manifestations

(Signed) R. W. Richardson. M. D.

, 19 (Address) Md. Genl. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenberry Pk	APR 4-21
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Fall Rd

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS it may be properly classified. Exact statement CAUSE OF DEATH in plain terms, so that TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52520

HEALTH DEPARTMENT—CITY OF BALTIMORE

87 D 52520

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lang

(a) RESIDENCE. No..... ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	63.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 87

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Unknown (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address) Hospital Records, New City Hospital. UNIVERSITY OF MARYLAND

15 Filed APR 1 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1921 to March 29, 1921.

that I last saw h... alive on March 29, 1921.

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(No cerebral hemorrhage

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile dementia.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? No especial test

(Signed) R. Hartman M. D.

3/30/ 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

APR 1 - 1921

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D 52521

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 638 So.Linwood Ave ST.: 1- WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME STANISLAUS STNCIAK,

(a) RESIDENCE. No. 638 So.Linwood Ave ST., 1- WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26/21.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant,

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.,

PARENTS

10 NAME OF FATHER Alexander Stnciak,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Stanislawa Wotekiewicz,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania,

14 Informant Alexander Stnciak, (Father)

(Address) 638 So.Linwood Ave

15 Filed APR 1 - 1921 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1921, to April 1, 1921, that I last saw him alive on April 1, 1921, and that death occurred, on the date stated above, at 8.00 A. m.

The CAUSE OF DEATH* was as follows:

Acto Ectasis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation preeede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm O'Donnell, M. D.

4/1/21, 19 (Address) 801 S Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
ST. STANISLAUS CEMETERY	APRIL 3 1921
20 UNDERTAKER M F. Sadowski.	ADDRESS 705 S Ann

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52522 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52522

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1204 W. Mulberry ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza D. Browne

(a) RESIDENCE. No. 1204 W. Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene H. Brown Deceased

6 DATE OF BIRTH (month, day, and year) April 12 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Brackett Wooley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Anne M. B. Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Maryland

14 Informant Miss Eda L. Browne

(Address) 1204 W. Mulberry St.

15 Filed Robert P. Harrison, Jr. Registrar

APR 1-1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1917, to April 1, 1921, that I last saw her alive on March 31, 1921, and that death occurred, on the date stated above, at 9-30 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis (chronic)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremic poisoning

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At her home 1204 Mulberry St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic analysis (examination)

(Signed) John D. Kemp, M. D.

April 1921 (Address) 1425 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 4 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52523 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

150 D 52523

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 916 N. Milton Ave ST.: 7 WARD)

2-FULL NAME Minnie L. Schaaf

(a) RESIDENCE. No. 916 N. Milton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced~~ (write the word)
Female	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Schaaf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Minnie L. Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John Schaaf (Address) 916 N. Milton Ave

15 Filed APR 1 - 1921 19.... Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 — 1 19 21

17

I HEREBY CERTIFY, That I attended deceased from ....., 19....., to 4 — 1, 19 21

that I last saw her alive on 4 — 1, 19 21

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows: Congenital Heart Trouble

(duration) yrs. 2 mos. 28 ds.

CONTRIBUTORY (Secondary) acute edema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Autopsy

(Signed) F F Rubyera M. D.

1. 19 21 Address) 1001 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	April 2 1921
20 UNDERTAKER	ADDRESS
Jas C. Miller	233 E Jefferson St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 52524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 VD 52524

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 E. Oliver ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Geo. Parker Murphy

(Residence in Baltimore: No. 1215 E. Oliver St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Nov. 19, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 4 mos. 12 ds. If LESS than 1 day, ~~... hrs. or ... min.~~

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Geo. W. Murphy

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lela Smithers

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Murphy

(Address) 1215 E. Oliver St

15-

Filed..... 191... Robert T. Harris Registrar.

APR 2 - 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 31, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 24, 1921, to Mar. 31, 1921, that I saw h... alive on Mar. 31, 1921, and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Congenital debility

..... (Duration) ..... yrs. 4 mos. ..... ds.

(Signed) L. Lee Magruder M. D.

April 2, 1921 (Address) 1108 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, 4/2/21, 191...

20-UNDERTAKER Geo. J. Roth ADDRESS 175 Hanford Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52525

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 52525

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 556 Robert St.: 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Addison

(Residence in Baltimore: No. 556 Robert St.: 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	widow

6-DATE OF BIRTH, Sept. 5, 1840
(Month) (Day) (Year)

7-AGE, 80 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Anne Arundel Co, Md,

PARENTS.

10-NAME OF FATHER, Thos. Byrne

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Addison

(Address) Annapolis, Md.

15- Robert P. Harrison, ..., 191.....
Burial Permit Clerk. Registrar.

APR 2 - 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to (her) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
5 months

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) C. S. Hennesby M. D.
(Coroner.)

April 1, 1921 (Address) 2802 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, 13 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Brewer Hill Annapolis	April 3, 1921
20-UNDERTAKER	ADDRESS
C L Hopkins	Annapolis Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52526

X 45

CERTIFICATE OF DEATH.

REGISTERED No. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Kate Harding

(a) RESIDENCE. No. 715 N. Carrollton Ave. ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm. J. Harding

6 DATE OF BIRTH (month, day, and year) Jan 12 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salto Md.

PARENTS

10 NAME OF FATHER Robert A. Easter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anna Easter (Address) 216 Rhode Island ave. Washington D.C.

15 Filed Apr 2 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/1 1921, to 4/1 1921, that I last saw h.. alive on 4/1 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of mediastinal Glands

(duration) 1 mo. yrs. mos. ds.

CONTRIBUTORY (Secondary) asphyxiation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Emma D. Rudy M. D.

(Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ellicott City Md	Apr 4 1921
20 UNDERTAKER John O. Mitchell	ADDRESS 1201 W Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-10—Ill. P. Co.—1000 Blks.

D 52527

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

Michael

1-PLACE OF DEATH US. Public Health Hosp. #56 — REGISTERED NO. D 52527

CITY OF BALTIMORE: (NO. Fort McHenry Baltimore Md. ST.: 30 WARD) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Michael

2-FULL NAME Mitchell P. Loughran

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST., Fort WARD. McHenry Baltimore Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40 yrs.	--	--	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Seaman 2nd asst Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) ---- 30

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rambo Registrar
(Address) US. PHS Hosp. #56 Ft. McHenry Md.

15 Filed APR 2 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to March 31, 1921, that I last saw h... alive on March 31, 1921, and that death occurred, on the date stated above, at 10'35 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia broncho .

13 days/ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Thomas R. Payne Senior Surgeon (R.) M. D.

, 19 (Address) US. PHS. Hosp. #56 Ft.McHenry M...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 2. 1921
20 UNDERTAKER	ADDRESS
H. Thomson & Bro	127 E Baltimore St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

350

D 52528 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52528

172

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Lt Dr. Henrietta~~ Andrew L. Mellon

(Residence in Baltimore: No. 14 W Henrietta St.; yrs., 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): Rr Co

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, James Mellon

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Louisa Trout

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mellon

(Address) .....

15- Filed APR 2 1921 Robert P. Harrison, Burial Permit Clerk, 191 .... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 1 ....., 191[illegible]
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....Inquest..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull
fall on steel pavement

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner.)

Apr 1, 191[illegible] (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	4—4, 192
20-UNDERTAKER	ADDRESS
Mrs Chas A G Rohde	600 N Carlington Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52529

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52529

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 16 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Hattie Spencer

(a) RESIDENCE. No. 621 N. Carey St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mr. Samuel Spencer

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Katie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant, Hospital (Address)

15 Filed APR 2-1921, Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/17 1921, to 4/1 1921, that I last saw h... alive on 4/1 1921, and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Multiple Abscess of Bone

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intramural Fibroid Tumor

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lewis D. Ridgely, M. D.

4/1, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Roanoke Va.	4-2-21
20 UNDERTAKER	ADDRESS
Mrs Chas A G. Rohde	600 Marlyn Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

20,52530 HEALTH DEPARTMENT—CITY OF BALTIMORE 20,52530

CERTIFICATE OF DEATH.

37

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.; 7 WARD)

2-FULL NAME Clinton Gladding Jr.

(a) RESIDENCE. NO. 2632 Mc Elderry st. City ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 21 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 6 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
		2	~~16~~ 15 das	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salt, Md

PARENTS

10 NAME OF FATHER Clinton Gladding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Mrs. Gladding

(Address) 2632 Mc Elderry st City

15 Filed ____, 19 ____ Robert F. Harris Registrar

APR 2 - 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-29, 1921, to 4-1, 1921,

that I last saw him alive on 4-1, 1921,

and that death occurred, on the date stated above, at 5-15 A m.

The CAUSE OF DEATH* was as follows:

Syphillis - congenital

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann

(Signed) H. M. Craig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Apr 2 19

20 UNDERTAKER Wm J Tickner & Son — ADDRESS N Y Pa

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52531

CERTIFICATE OF DEATH

REGISTERED NO. 91-146

1-PLACE OF DEATH South Baltimore Gen'l. Hospital
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1213 Light ST. 22 WARD)

2-FULL NAME Dorothy Hippler

(a) RESIDENCE. NO. 809 E. Fremont ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Infant.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29. 1920

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER John Hippler
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Lilly M. Ballen
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Hippler
(Address) 809 E. Fremont

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31- 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-28- 1921, to 3-31 1921, that I last saw her alive on 3-31 1921, and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

mastoiditis

(duration) — yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 3-15-21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard L. Tolson M. D.

, 19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park.
DATE OF BURIAL: April 4 1921

20 UNDERTAKER: L. W. Dill
ADDRESS 3109 Fredk. Ave.

D 52532

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 152 N. East Ave ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine L Smith

(a) RESIDENCE. No. 152 N East Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 24 ds. How long in U. S., If of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 7 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles F Smith

11 BIRTHPLACE OF FATHER (city or town) Altona (State or country) Indiana

12 MAIDEN NAME OF MOTHER Grace E Simpson

13 BIRTHPLACE OF MOTHER (city or town) Orange (State or country) Va.

14 Informant Charles F Smith

(Address) 152 N East Ave.

15 Filed: APR 2 1921, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17

I HEREBY CERTIFY, That I attended deceased from March 31st, 1921, to April 1st, 1921, that I last saw her alive on March 31st, 1921, and that death occurred, on the date stated above, at 9.2 m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Croup)

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Croup.

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy? ...

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	APR 2 1921 19
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nasal.

Membranous.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52533

CERTIFICATE OF DEATH.

D 52533

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. no new Sassafras ST.; 25 47 WARD)

2-FULL NAME John J. Foosley. no name Mt Winans

(Residence in Baltimore: No. Sassafras & Mt Winans St. Life yrs., mos. ds.)

MARGIN RESERVED FOR USE OF REGISTRAR

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

any 9, 1831

7-AGE,	If LESS than 1 day,
89 yrs. 7 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Thos Fosley

11-BIRTHPLACE OF FATHER (State or Country), D.C.

12-MAIDEN NAME OF MOTHER Elizabeth Stevens

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amanda S. Smith

(Address) Mt Winans

15-

Filed ..... 1921. Robert P. Harrison, Registrar.

APR 2 - 1921 Burial Permit (Clerk).

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 31 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 23 1921, to March 30 1921, that I saw h[illegible] alive on March 30 1921, and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) old age & Rheumatism

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) T B Hall M. D.

4/ 1, 1921 (Address) Halethorp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... d

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Apl 2, 1921
20-UNDERTAKER	ADDRESS
Clark & Timmes	1822 N Pine

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52534

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52534

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 210 S. Ann St., ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harris Meltzer

(a) RESIDENCE. No. 210 South Ann ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Meltzer

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing 08

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E. Balto. St.

15 Filed APR 2 - 1921 . 19 Robert F. Hartman Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 19 21

17 I HEREBY CERTIFY, That I attended deceased from June 14 19 20 to April 1 19 21.

that I last saw h[illegible] alive on March 31 19 21.

and that death occurred, on the date stated above, at 12. 50 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary disease of Heart

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

4/1 . 19 21 (Signed) H. L. Gilroy M. D.

(Address) 6 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Hebrew Rosedale 4/3/21 19

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52535 D 52535

CERTIFICATE OF DEATH.

X 550

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Childrens Hospital School St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Morris

(Residence in Baltimore: No. ——— Childrens Hosp. School St.; — yrs., 2 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W.

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.) Single

6-DATE OF BIRTH, X Unknown (Month), ... (Day), 1908 (Year)

7-AGE, 12 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, William J Morris

11-BIRTHPLACE OF FATHER (State or Country), Queen Anns Co. Maryland

12-MAIDEN NAME OF MOTHER Stella Smith

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

X (Informant) Mary Morris

(Address) 2601 St Benedict St.

15-

Filed ..... Robert P. Harrison, Registrar.

APR 2 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 1st (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 2nd 1921, to April 1st 1921, that I saw h.er alive on April 1st 1921, and that death occurred, on the date stated above, at 1.25 P.m.

The CAUSE OF DEATH* was as follows:

Postoperative Acidosis following Corrective Osteotomy of both femora on March 28th

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Robert W Johnson Jr M. D.

April 1st 1921. (Address) 4 E. Madison St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. 2 mos. — ds. In the State 12 yrs. — mos. — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Henderson, Caroline Co. Md

19-PLACE OF BURIAL OR REMOVAL, Henderson Caroline Co Md — DATE OF BURIAL, April 1 1921

20-UNDERTAKER Bertram Gore — ADDRESS 1753 W Lafayette Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52536

CERTIFICATE OF DEATH.

40 D 52536

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 623 N. Mount St ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Dietrich

(a) RESIDENCE. No. 623 N. Mount St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14. 1869

7 AGE — Years: 51 — Months: 11 — Days: 17

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Baptis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Lavander

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Katie Starcher

(Address): 623 N. Mount St

15 Filed APR 2 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1921

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1921, to March 31, 1921, that I last saw h[illegible] alive on March 31, 1921, and that death occurred, on the date stated above, at 6.10 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Kleinop, M. D.

4-2, 1921 (Address) 5 No. N. Fremont ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 4-4-1921

20 UNDERTAKER: H. C. Brauning Son

ADDRESS 617 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52537

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 52537

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1351 Whatcoat ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Tyler

(a) RESIDENCE. No. 1351 Whatcoat ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Basil M Tyler

11 BIRTHPLACE OF FATHER (city or town) Pikesville (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Davis

13 BIRTHPLACE OF MOTHER (city or town) Woodlawn (State or country) Maryland

14 Informant Basil M. Tyler
(Address) 1351 Whatcoat St

15 Filed Robert P. Harrison, Registrar
APR 2 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to Apr 1, 1921, that I last saw h/m alive on March 31, 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Prematurity.
(3 4 lbs foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann Test

(Signed) Morris Reese, M. D.

4-1, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem Liberty rd	Apr 3 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1651 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52538

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52538

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 S. Collington ave ST.; 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Pistel

(a) RESIDENCE. NO. 112 S. Collington ave ST., 2 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah V. Pistel

6 DATE OF BIRTH (month, day, and year) Jan. 12 - 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Pistel

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jennie Pistel

(Address) 112 S. Collington ave

15 [illegible] 1921, 19 Robert F. [illegible] Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31st 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch. 22 1921, to March 31, 1921, that I last saw him alive on March 30, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? physical Signs

(Signed) Leo Seidel, M. D.

4-1, 1921 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forrest Lawn	4-2 1921
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52539

CERTIFICATE OF DEATH.

28

D 52539

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 21 WARD)

2-FULL NAME Robert Warner

(a) RESIDENCE. No. 807 S. Paca St. ST., WARD.

(Usual place of abode)*

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Seattle

(State or country) Washington

PARENTS

10 NAME OF FATHER John Warner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Michigan

12 MAIDEN NAME OF MOTHER Anna Thompson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) British Columbia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed APR 2 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1921, to March 31, 1921, that I last saw him alive on March 31, 1921, and that death occurred, on the date stated above, at 8.35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous broncho pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum.

(Signed) Leo S. Fahndrich. M. D.

4-1-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 2 1921
20 UNDERTAKER	ADDRESS
Geo Leimbach Co	6874 Belair

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52540

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 52540

CERTIFICATE OF DEATH.

X 150

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edward Wise

(a) RESIDENCE. NO. Park Hall, Md. ST.. WARD. Park Hall Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/6/20

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Park Hall, Md

PARENTS

10 NAME OF FATHER Henry C Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mother Mary Wise Park Hall, Md

15 Filed APR 2 - 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1 19 21

17 I HEREBY CERTIFY, That I attended deceased from 2/9, 19 21, to 4/1, 19 21, that I last saw him alive on 4/1, 19 21, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Pneu Tub - Chr Pulm

(duration) yrs. 3 mos. 26 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Irma Grigsby, M. D.

4/1, 19 21 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Millstone Md	4/2/21

20 UNDERTAKER Geo G Fraley Sutton ADDRESS Sayville

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52541

D 52541

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 401 N. Collington ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Morris

(a) RESIDENCE. No. 401 N. Collington Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~

~~(or) WIFE of~~ (or) WIFE of George Morris

6 DATE OF BIRTH (month, day, and year) Feb 28-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo. Sprague

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Rose Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Louis Sprague

(Address) ~~Allen Place~~ ~~Apt~~ Preston St

15 Filed APR 2 - 1921 Robert P. Harris M.D., Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 25, 1921, to April 2, 1921, that I last saw him alive on April 1, 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

Senility (duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Alvin T B Lemmon M. D.

4/2 1921 (Address) 718 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	April 5 1921
20 UNDERTAKER	ADDRESS
Joseph Adrens	2211 Boundary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(George E. Cook)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52542

CERTIFICATE OF DEATH.

91 D 52542

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3674 Oak St. St.: 13 WARD)

2-FULL NAME Geo E. Cook

(a) RESIDENCE. No. 3674 Oak St St., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 28. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Hubert M Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ruth E Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hubert M Cook (Address) 3674 Oak St

15 Filed APR 2 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 29th, 1921, to to April 1, 1921, that I last saw him alive on Mar 29, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? No

(Signed) B. G. Lillich, M. D.

4/1. 1921 (Address) 1527 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shrewsbury, Pa.	April 3 1921

20 UNDERTAKER Horace Burgee Son ADDRESS 363 Stalls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D 52543

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto. Gen Hospital ST. WARD 9)

2-FULL NAME Baby Wilson

(a) RESIDENCE. No. 614 S. Fremont Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-1-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lola Skelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) John Wilson 614 S Fremont ave

15 Filed APR 2 - 1921 16 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-1-, 1921, to 4-1, 1921, that I last saw h[illegible] alive on 4-1, 1921, and that death occurred, on the date stated above, at 11-15 m.

The CAUSE OF DEATH* was as follows:

Asphyxia.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes Clotted mass - lung - blood.

What test confirmed diagnosis? .....

(Signed) R. R. Reynolds, M. D.

, 19 (Address) 121 B Lyndhurst

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apl 2, 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	705 Hanover

Daniel Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Sierszen) ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52544

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52544

8-091

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Lancaster ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Sierszen

(a) RESIDENCE. NO. 1609 Lancaster ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Stanislaw Sierszen

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Czeslawa Borowa

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Stanislaw Sierszen
(Address) 1609 Zancaster St

15 Filed APR 8 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/30, 1921, to 4/1, 1921, that I last saw h[er] alive on 4/1, 1921, and that death occurred, on the date stated above, at 530A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia & Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/2 1921 (Address) 1623 South Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 2 1921
20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52545 ✓ D 52545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 W. Ostend ST. 21 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph L. Johns

(a) RESIDENCE. No. 816 Ostend ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Johns

6 DATE OF BIRTH (month, day, and year) June 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Johns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances See

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie Johns (Address) 816 Ostend St

15 APR3-1921 ROBERT F. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/31/21 to 3/31/21, that I last saw him alive on 3/31/21, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

history about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(No Doc) History about 1 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

4/2/21 (Address) 908 Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apl 3 1921
20 UNDERTAKER John A Toadvine	ADDRESS 142 Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Nephritic
in Character.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52546 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52546

CERTIFICATE OF DEATH.

REGISTERED No. C 42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womens Hospital ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Lillie Whitefoord

(Residence in Baltimore: No. 1526 Poplar Grove St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Divorced

6-DATE OF BIRTH, June (Month) 23" (Day), 1872. (Year)

7-AGE 48 yrs. 9 mos. 10 ds. If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: matron
(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Orphan Asylum

9-BIRTHPLACE, (State or Country), Delta, Pa.

PARENTS.

10-NAME OF FATHER, Hugh W. Ramsay

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Percilla Hatton

13-BIRTHPLACE OF MOTHER (State or Country), Lancaster County, Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. Irving Morgan

(Address) 1526 Poplar Grove St.

15-

Filed APR 3 - 1921 ROBERT J. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 22 1921, to apr. 2d 1921, that I saw her alive on Apr. 2d 1921, and that death occurred, on the date stated above, at 8 50 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cancer of Cervix Uteri

(Duration) ....yrs. ....mos. ....ds.

(Signed) R Brack M. D.

Apr 2, 1921 (Address) Womens Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 11 ds. In the State 30 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Baltimore Orphan Asylum

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
London Park	April 4, 1921

20-UNDERTAKER	ADDRESS
Jos B Cook	101 3 Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52547

CERTIFICATE OF DEATH.

50 D 52547

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Stewart

(a) RESIDENCE. No. 808 S. Fremont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant (Address) Hospital Records, New City Hospital.

15 Filed APR 3 - 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1920, to April 1, 1921

that I last saw her alive on April 1, 1921,

and that death occurred, on the date stated above, at 9:35 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(No cerebral hemorrhage)
old cerebral thrombosis)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) V B Steiman, M. D.

4/2/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 5 1921
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52548

CERTIFICATE OF DEATH.

154 D 52548

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 S Woodyear ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Anderson

(a) RESIDENCE. No. 312 S Woodyear ST. 19 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen J. Anderson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Stephen J. Anderson

(Address) 312 S. Woodyear St

15 Filed APR 3 - 1921 19.... ROBERT J. CRAWFORD Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/21

17 I HEREBY CERTIFY, That I attended deceased from 2/15/21, 19.... to 4/2/21, 19....

that I last saw h.... alive on 4/2/21, 19....

and that death occurred, on the date stated above, at 1 10 P m.

The CAUSE OF DEATH* was as follows:

Anthrax

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) F. H. Wenck, M. D.

4/2, 19.... (Address) 1302 N Broadway St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 5 1921
20 UNDERTAKER Jos B. Cook	ADDRESS 503 N Balto St

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52549

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52549

CERTIFICATE OF DEATH.

136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie M Banks.

(a) RESIDENCE. NO. 1718 Keyser ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) February 22, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	14	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Cambridge Maryland.

PARENTS

10 NAME OF FATHER George W. Banks.

11 BIRTHPLACE OF FATHER (city or town) Cambridge (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Hattie E Cornish

13 BIRTHPLACE OF MOTHER (city or town) Cambridge (State or country) Maryland.

14 Informant Mother (Hattie E Banks)

(Address) 1718 Keyser St City

15 DATE APR 3 - 1921 ROBERT J. KRAMER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 31st 1921, to April 1st 1921, that I last saw h[illegible] alive on April 1st, 1921, and that death occurred, on the date stated above, at 4:45 A m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) 26 hours mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of March 31st 21

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J Morris Reese, M. D.

4 1, 19 21 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md.	Apr 4 1921
20 UNDERTAKER Samuel L Newsley	ADDRESS 776 N Bible

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Caesarean Section

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52550

D 52550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1337 Calhoun St ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wright

(a) RESIDENCE. NO. 1337 Calhoun St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) May 31-1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	-	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Longshoreman

(b) General nature of industry, business, or establishment in which employed (or employer) Ore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md

PARENTS

10 NAME OF FATHER Augustus Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rachel Davis

(Address) 1337 Calhoun St

15 Filed APR 3 — 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1921

17

I HEREBY CERTIFY, That I attended deceased from Mch 30th, 1921, to April 1st, 1921, that I last saw h in alive on Mch 30th, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pleurisy

AWW

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Found in Sputa

(Signed) A. C. Samuels, M. D.

April 3 1921 (Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union Chapel Liberty	April 3 1921
20 UNDERTAKER	ADDRESS
Samuel J Hemsley	1 N Bridle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52551

CERTIFICATE OF DEATH.

120 D 52551

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 889 W Fayette ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Walter Thomas Duncan

(a) RESIDENCE. No. 889 W. Fayette St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma B. Duncan

6 DATE OF BIRTH (month, day, and year) Aug 13 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Sarah Dimond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Hadden Nelson (Address) 889 W Fayette St

15 Filed APR 3 - 1921 ROBERT J. TRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1920, to April 1, 1921, that I last saw him alive on March 31 1921, and that death occurred, on the date stated above, at 8-30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Uremia

(duration) 5 yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Eye-

(Signed) Henry C. Ohler, M. D.

, 19 (Address) 1203 W. Fayette st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	April 4 1921
20 UNDERTAKER	ADDRESS
H. McCord	W & G Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL INFORMATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1203 W. Fayette.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52552

CERTIFICATE OF DEATH.

28 D 52552

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 W. Hamburg ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary. G. Redmond

(a) RESIDENCE. No. 1109 W. Hamburg ST.

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. c mos. c ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed,~~ or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Philip. H. Redmond

6 DATE OF BIRTH (month, day, and year): Nov 8 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32.	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Stokes County N.C.

PARENTS

10 NAME OF FATHER: Eugene Brewer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Stokes Co. N.C.

12 MAIDEN NAME OF MOTHER: Mary. Grave

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Stokes Co. N.C.

14 Informant: Philip. H. Redmond

(Address) 1109 W. Hamburg St

15 Filed APR 3 - 1921 ROBERT J. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan — 1920, to March 31, 1921, that I last saw h[illegible] alive on March 31, 1921, and that death occurred, on the date stated above, at 7 55 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. 3 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/1. 1921 (Address) 511 Lodge St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 4 1921
20 UNDERTAKER	ADDRESS
Jos Jacobs & Son	27 S. Paca

N. B.—WHITE CARDS, when carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 52553
REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2128 W. Fairmount Ave ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James C. Reck

(Residence in Baltimore: No. 2128 W. Fairmount Ave St.; 33 yrs., 6 mos. 1 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May 29, 1851
(Month) (Day) (Year)

7-AGE, 69 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer)..... Not Employed

9-BIRTHPLACE, (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, Henry Reck

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oscar D. Reck

(Address) 2128 W. Fairmount Ave

15- Filed APR 3 - 1921 ROBERT A. CRAUTER Deputy Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 31, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1921, to Apr. 1, 1921, that I saw him alive on Mar. 31, 1921, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Hackney M. D.

Apr. 1, 1921. (Address) 14 N. Thomson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, April 4, 1921.

20-UNDERTAKER for. Joerdans Son ADDRESS 217 S. Broadway

Engel.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52554 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52554

CERTIFICATE OF DEATH.

28-092

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Pressbury ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Engle

(a) RESIDENCE. No. 2500 Pressbury ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Engle

6 DATE OF BIRTH (month, day, and year) Oct 15/1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jack S Zittle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hancock Md

12 MAIDEN NAME OF MOTHER Mary Helen Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Paul Engle (Address) 2500 Pressbury St

15 Filed APR 3 - 1921 [illegible] Registrar

Burial Permit Given

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Apr 1, 1921, that I last saw h[illegible] alive on March 31, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) about 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diognosis? Physical

(Signed) W S Hubbett, M. D.

Apr 1, 1921 (Address) 2220 Garrison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	April 4 1921

20 UNDERTAKER ADDRESS

Ufford 502 E Northam

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52555

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 S. East Ave ST.: 26 WARD)

2-FULL NAME Minnie C. Sherrill.

(a) RESIDENCE. No. 603 S. Eastave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Thurman Sherrill

6 DATE OF BIRTH (month, day, and year) Sept 9-1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	1.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Benson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Francis Carson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Margaret A. McGee
(Address) 603 S. East ave.

15 FILED APR 3 - 1921 ROBERT I. KRAUTZ Registrar
Burial Permit Given

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 1 - 1921

17

I HEREBY CERTIFY, That I attended deceased from — , 1918 , to April 1 , 1921 , that I last saw h ex alive on April 1 , 1921 , and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ... yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What lest confirmed diagnosis? Physical & microscopical

(Signed) M. Hirandorf, M. D.

, 19 (Address) 1707 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthias	4-4 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E North Ave

By Undertaker

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52556

CERTIFICATE OF DEATH.

D 52556
1-PLACE OF DEATH

REGISTERED NO. 64

CITY OF BALTIMORE: (No. 1514 Baker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Carter

(a) RESIDENCE. No. 1514 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wht	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Jessie Anderson

6 DATE OF BIRTH (month, day, and year) Dec 29/66

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 086

(b) General nature of industry, business, or establishment in which employed (or employer) School Janitor

(c) Name of employer Balto City Schools Balto Md

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jno. Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Beula Carey
(Address) 1518 N Gilmor St

15 Filed APR 3 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1st, 1921, to Apr. 2nd, 1921, that I last saw him alive on Apr. 2, 1921, and that death occurred, on the date stated above, at 5:10 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Brain Hemorrhage
6 hrs
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma two years.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Ed Lentz M. D.

4/2, 1921 (Address) 1600 N North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Apr 5 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E Balto

—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52557

114

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 Carroll St - ST.: 21 WARD)

2-FULL NAME Katie A. Craig

(a) RESIDENCE. No. 1420 Carroll St - ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of - Charles L Craig

6 DATE OF BIRTH (month, day, and year) July 24th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work. 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John W Bryson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Caroline Muller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Charles W Craig
(Address) 1420 Carroll St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1/1921

17 I HEREBY CERTIFY, That I attended deceased from 3/28/21, 1921, to 4/1/21, 19..., that I last saw h-m alive on 3/31/21, 19..., and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Sepsis Infection

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Post operation (Gall Stones)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo. Lucas M. D.

19 (Address) 1727 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 4th 1921
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52558

CERTIFICATE OF DEATH.

28 D 52558

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3005 Mathews St. (ST.:) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Xavier Pulley

(a) RESIDENCE. NO. 3005 Mathews St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) September 27th 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper Shipping

(b) General nature of industry, business, or establishment in which employed (or employer) Engineers. 030 Engineers.

(c) Name of employer Union Comp Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm H Pulley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Winifred A. Flanigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas Balto county

14 Informant William Pulley
(Address) 3005 Mathews St

15 Filed APR 3 - 1921 19 ROBERT B KRAUSE Registrar
Burial Permit Dist

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2nd 1931

17 I HEREBY CERTIFY, That I attended deceased from June 28th, 1931, to August 2nd, 1931, that I last saw her alive on August 2nd, 1931, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Frankenstein Brown M. D.

Aug. 3 1931 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Texas-Balto Co	April 5 1931
20 UNDERTAKER	ADDRESS
E A Widefeld Jr	501 E 22nd St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL items should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52559

CERTIFICATE OF DEATH.

170 D 52559

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 E Preston ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas A. McGovern Jr

(Residence in Baltimore: No. 932 E Preston St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Single

6-DATE OF BIRTH, April (Month) 29 (Day) 1905 (Year)

7-AGE. 15 yrs. 11 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas A McGovern

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emily Leland

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. A. McGovern

(Address) 932 E. Preston St

15-APR 3 - 1921

Filed....., 191.....

ROBERT F. KRAUTH
Burial Permit Recorder

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3/28 1921, to 4-1 1921, that I saw h[e] alive on 4-1 1921, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease

..... (Duration) 6 yrs. ....mos.....ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

..... (Duration) ....yrs.....mos. 4 ds.

(Signed) Dr. Thomas O Wills M. D.

4/x....., 1921 (Address) 614 E Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	April 4, 1921
20-UNDERTAKER	ADDRESS
E A Wiedefeld & Son	501 E 22nd St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52560

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52560

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 1603 Shakespeare St. ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Goeztollowiz

(Residence in Baltimore: No. 1603 Shakspeare St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	

6-DATE OF BIRTH, March 17 1921, 1
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 17 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Standly Goeztollowiz

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Rose Donlopshi

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Standly Goeztollowiz

(Address) 1603 Shakspeare St.

15- APR3-1921 ROBERT E KRAUSE

Filed ....., 191... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 3. 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inveatigath (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) investigation and that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Stanley Gus Gustay M. D.
(Coroner.)

4/3, 21 (Address) 1600 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Mary's Capella	April 4/21 19....
20-UNDERTAKER	ADDRESS
Wendell Dippel & Son	37 S. Ann

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH PEN AND INK.

Spec.—6-9-19.—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52561

D 52561

81

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3061 Stafford ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Spencer

(a) RESIDENCE. NO. 3061 Stafford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 7 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Wm Lawderin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Mary Bowlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Ella M Hadden

(Address) 3061 Stafford

15 Filed APR 3 - 1921 19 ROBERT J. KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1919, to April 1, 1921, that I last saw h[illegible] alive on March 30, 1921, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) old age. Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. W. Jones, M. D.

(Address) Dunglen

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL April 4 1921

20 UNDERTAKER C. W. Dill

ADDRESS 3109 Fredk. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52562 ✓ D 52562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora B. Brumage

(a) RESIDENCE. NO. Metz W. Virginia ST.. WARD. Metz W Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Enos Brumage Same address

6 DATE OF BIRTH (month, day, and year) Aug 8 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Nathan Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Sarah Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant J. H. Hospital Records (Address)

15 Filed APR 3 - 1921 ROBERT E KLAUTZ Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to April 3rd, 1921, that I last saw her alive on April 3rd, 1921, and that death occurred, on the date stated above, at 1.56 A m.

The CAUSE OF DEATH* was as follows:

Respiratory Failure
Cardiac Failure
(Surgical Shock)
12 hours

(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Obstructive Hernia (duration) 8 1/4 yrs. mos. ds.
Intestinal Stone (Left)

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Yes Date of 4/2/21

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) A. B. Kidd M. D.

4-3-1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Metz W Va	4/3/21
20 UNDERTAKER	ADDRESS
J E Hughes	424 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52563

CERTIFICATE OF DEATH.

28 D 52563

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N. Lakewood Ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas N. White

(a) RESIDENCE. No. 108 N. Lakewood Ave ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mrs. Dora White

6 DATE OF BIRTH (month, day, and year) April 25 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pharmacist

(b) General nature of Industry, business, or establishment in which employed (or employer) Drug business.

(c) Name of employer Wm. Otto

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward T White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bermuda

12 MAIDEN NAME OF MOTHER Lucy Bancroft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Edward T White

(Address) 108 N. Lakewood Ave

15 Filed APR 3 - 1921, 19.. ROBERT A KRAUSE Registrar

Burial Permit 01008

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to April 1, 1921, that I last saw him alive on April 1, 1921, and that death occurred, on the date stated above, at 12 50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Alan B Lemon, M. D.

4/2, 1921 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 4 1921
20 UNDERTAKER Robt J Turner Inc	ADDRESS 144 E Biddle St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRY must be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

D 52564

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

97 D 52564

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 406 N Milton Av ST.: 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas L Smith

(Residence in Baltimore: No. 406 N Milton Av ST.: yrs. 1/2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M

4-COLOR OR RACE: W

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Mar'd

6-DATE OF BIRTH: January 9, 1849 (Month) (Day) (Year)

7-AGE: 72 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Can Business
(b) General nature of industry, business, or establishment in which employed (or employer): W5

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Wm H Smith

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Henrietta M Lee

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul J Smith

(Address) 406 N Milton Av

15-Filed APR 3 - 1921 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April 2, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1921, to April 2, 1921, that I saw him alive on April 1, 1921, and that death occurred, on the date stated above, at 6 PM. The CAUSE OF DEATH* was as follows:

Pulmonary Emphysema (Senile) (Duration) yrs. mos. ? ds

Contributory (SECONDARY) To my knowledge (Duration) yrs. 2 mos. ? ds.

(Signed) C L Smith M. D.

April 2, 1921 (Address) 301 Elwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltpennsley — DATE OF BURIAL: April 4, 1921

20-UNDERTAKER: Robt Turner — ADDRESS: 1212 Pratt

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Due to senility. No further history

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52565

CERTIFICATE OF DEATH.

37 D 52565

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertram Wallace Stansbury

(Residence in Baltimore: No. 1315 E. North ave. St.; Wife yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 6 (Day), 1899 (Year)

7-AGE, 21 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): Truck # 5

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Thomas H Stansbury

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Elzabeth Hall

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) LeRoy H Stansbury

(Address) 3 Susquehanna St. Towson

15- APR 3 1921 191... ROBERT P. HEATWOLE Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 3rd. (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1st 1921, to apr. 3rd. 1921, that I saw h/m alive on apr. 3rd. 1921, and that death occurred, on the date stated above, at 6:00 A. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cirho. Spinal bulb

(Duration) 18 yrs. mos. ds.

(Signed) A S Zinberg M. D.

3/3/21, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. Md. DATE OF BURIAL, 4/5, 1921

20-UNDERTAKER Williams Coff ADDRESS 502 North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52566

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 52566

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Greenmount Ave WARD 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Callan

(a) RESIDENCE. No. 1108 Greenmount Ave WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of James A. Callan

6 DATE OF BIRTH (month, day, and year) April 6/1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Raizen Poole

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Margaret Cahill

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Mrs. Richard Holtman

(Address) 1108 Greenmount Ave

15 Filed APR 3 - 1921 ROBERT A. BRAUNE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 25 1921 to April 2 1921 that I last saw her alive on April 2 1921 and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1108 Greenmount Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James W. Tuttle, M. D.

4-2, 1921 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 5 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Fait Ave

A. BURIAL PERMIT WILL NOT BE ISSUED UNLESS THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52567

CERTIFICATE OF DEATH.

91 D 52567

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Homewood ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Pickett

(a) RESIDENCE. No. 1116 Homewood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Pickett

6 DATE OF BIRTH (month, day, and year) Sept 2 - 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs James Bosworth
(Address) 2424 Maryland Avenue

15 Filed APR 3 - 1921 19.. Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24 1921, to April 1, 1921, that I last saw h.e alive on April 1, 1921, and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? 1116 Homewood ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Taylor, M. D.

4-3, 1921 (Address) 700 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ebenezer-M.E. Carroll Co.	April 4th 1921
20 UNDERTAKER	ADDRESS
William Ort	502 E North Ave

Dr Fenton Greene Chase Dist

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52568

30 D 52568

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 S. Gilmor. ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverta G. Brown.

(a) RESIDENCE. NO. 222 S. Gilmore ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard L. Brown

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm. Parker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Emma Belt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Howard L. Brown

(Address) 222 S. Gilmore

15 Filed APR 3 - 1921 [illegible] Registrar

Daniel Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 2 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar. 7, 1921, to Apr. 2, 1921, that I last saw her alive on Apr. 1, 1921, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Was confined on Mar. 7. 1921

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. T. Seabury, M. D.

4/2, 1921 (Address) 638 Ford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	4/5 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E Nash St.

A. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52569

HEALTH DEPARTMENT—CITY OF BALTIMORE

154 D 52569

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 N Lexington ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert J. Clazey.

(a) RESIDENCE. No. 1422 N Lexington ST., 19 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 4 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J. Clazey

6 DATE OF BIRTH (month, day, and year) Nov 15, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) #1

(c) Name of employer Bartlett Hayward Co.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Georg Clazey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Hiltzberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. W. Clazey

(Address) 1422 N. Lexington

15 Filed APR 4 - 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/15/21, 19..., to 3/31/21, 19..., that I last saw h... alive on 3/31/21, 19..., and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary) Oedema

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) F. W. Winn, M. D.

4/1, 19 21 (Address) 1302 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apr 4 '21

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Fayette St.

A. B. ... should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52570 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 52570

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF SALTIMORE: (No. New City Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Stanford

(a) RESIDENCE. No. 1233 Jefferson St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? ~~yrs.~~ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Prince George Co., Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records, (Address) New City Hospital.

APR 4-1921 Registered, 19 [illegible] Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2, 19 21

17 I HEREBY CERTIFY, That I attended deceased from January 9, 19 20 to April 2, 19 21

that I last saw h er alive on April 1, 19 21

and that death occurred, on the date stated above, at 12:30 Am.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency
(Luetic)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) [signature] M. D.

4/2/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn	April 4 1921
20 UNDERTAKER	ADDRESS
Mrs J. G. Locks	1302 Jefferson

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52571

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 52571

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1825 Mc Henry ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie I. Ramsey

(Residence in Baltimore: No. 1825 Mc Henry St., yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Oct (Month) 25 (Day), 1878 (Year)

7-AGE, 42 yrs. 8 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John T. Mondshour

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Susan Graham

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Ramsey

(Address) 1825 Mc Henry St.

15- APR4-1921 Filed....., 191.... ROBERT J. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 2 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy

(Duration) 11 yrs. mos. ds.

(Signed) James McFeeley M. D. (Coroner.)

April 3. 1921. (Address) 704 Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cem	Apr. 5. 1921
20-UNDERTAKER	ADDRESS
Margaret E. Flynn	1422 Light St.

Spec.—6-9-19—H. P. Co.—1000 Rks.

John G. Jay.

D 52572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 52572

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Jay.

(a) RESIDENCE. No. 909 Cathedral St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs John A Jay.

6 DATE OF BIRTH (month, day, and year) June 26, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Jay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jane Seevers Jay

(Address) 909 Washington Place

15 Filed APR 4 - 1921 ROBERT A. LEAVELL Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to April 1, 1921, that I last saw h~~im~~alive on April 1, 1921, and that death occurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis of Abdominal viscera.

(duration) 2 yrs.? mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Geo. E. W. Hardy M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 4 1921

20 UNDERTAKER Henry H Jenkins & Sons Co ADDRESS Eutaw & Lanvale Sts

N. B.—WRITE PLAINLY. Every question should be carefully answered. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52573

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 11 Ward)

REGISTERED No. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Margaret McDonough

(a) RESIDENCE. No. 1001 N Charles St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Edward McDonough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Dorrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Rosa McDonough

(Address) 1001 N Charles St

15 Filed APR 4 - 1921 ROBERT F. LEACHER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/29, 1921, to 4-2, 1921, that I last saw her alive on 4-2, 1921, and that death occurred, on the date stated above, at 4,30 P.m.

The CAUSE OF DEATH* was as follows:

Uremia

over

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinary & blood.

(Signed) A O Ridgely, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	4-4 1921
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Son Co	Richard McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state-mation should be carefully supplied. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Parenchymatous Nephritis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52574

CERTIFICATE OF DEATH.

8152

D 52574

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 Belair ave ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Krebs

(a) RESIDENCE. No. 2111 Belair ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. 5 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 31 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Frank H Krebs

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Susan Schwarz

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) md

14 Informant Hn Fennage
(Address) 2631 Calvert st

15 Filed APR 4 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 1921

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1921, to Apr 3, 1921; that I last saw her alive on Apr 2, 1921, and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Congenital deleterious

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY —
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physician

(Signed) Hn Fennage, M. D.

, 19 (Address) 2631 N Calvert st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	April 4 1921
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Hayford ave

Spec.—8-24-14—M. & T.—2000 Blks.

D 52575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18-010 D 52575

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 E. Lanvale ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice L. Richmond

(Residence in Baltimore: No. 1211 E. Lanvale St.; 10 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 10th, 1891
(Month) (Day) (Year)

7-AGE, 28 yrs. 11 mos. 22 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George O. Hess.

11-BIRTHPLACE OF FATHER (State or Country), Hanford Co. Md.

12-MAIDEN NAME OF MOTHER Margaret Riera

13-BIRTHPLACE OF MOTHER (State or Country), Hanford Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Hess

(Address) 1211 E. Lanvale St

15- Filed APR 4 - 1921 ROBERT A KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, APRIL 2nd, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from MAR 21 - 1921 191..., to APR 2 - 1921 191..., that I saw h CR alive on APR 2 - 1921 191..., and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Influenza & Erysipelas

(Duration) 2 yrs. X mos. 13 ds.

(Signed) G. H. Duke M. D.

APR 4 - 1921, 191... (Address) 928 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 yrs. — mos. — ds. In the State 11 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, April 5, 1921

20-UNDERTAKER George J. Ruth — ADDRESS 1735 Hanford Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1225 N. Caroline

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52576

CERTIFICATE OF DEATH.

D 52576

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 Aisquith St ST.; 5 WARD) REGISTERED NO. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachael Rosenberg

(Residence in Baltimore: No. 525 Aisquith Street St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- Filed APR 4 - 1921 191 ROBERT A KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 2d (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 1 1921 to Apr 3 1921, that I saw her alive on Apr 3 1921, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Septicemia

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia Congenital

(Duration) yrs. mos. 4 ds.

(Signed) J. W. Sherman M. D.

Apr 4, 1921 (Address) 2250 Eastern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Herring Run	April 4, 1921
20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Baltimore St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 D 52577

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2136 E North Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernestine Mabel Reinig

(Residence in Baltimore: No. 2136 E North Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, November 10, (Month) (Day) 1920 (Year)

7-AGE, ...yrs. 4 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Benjaman J Reinig

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Mabel T. Madden

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Benjaman Reinig

(Address) 2136 E North Ave

15- APR4 - 1921 Filed....., 191.... ROBERT A KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 4, (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 30 1921 to April 4 1921, that I saw h... alive on April 4 1921, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Dysentery

..... (Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Albert Buttorff M. D.

Apr 4, 1921, (Address) 1200 N Howard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mount Carmel — DATE OF BURIAL, April 6, 1921

20-UNDERTAKER Louis Hoemann — ADDRESS 826 Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52578

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52578

CERTIFICATE OF DEATH.

78

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Colston

(a) RESIDENCE. NO. Hartinsburg W. Va ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 0 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 52 yrs 7-20-69 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52	0	0		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Berkly Co W. Va

PARENTS

10 NAME OF FATHER William Colston

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Virginia -

12 MAIDEN NAME OF MOTHER Marion — (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Maryland

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Baltimore -

15 APR 4 - 1921 BURNEY F. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1921

17 I HEREBY CERTIFY, That I attended deceased from April 17th, 1917, to Apr 4, 1921, that I last saw h. alive on Apr 4, 1921, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis -

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) Chr. Recurrent Melancholia -

Abt (duration) 25 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Virginia -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. F. Lowry, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mantisburg Lot Pat Apr 4/ 1921

DATE OF BURIAL

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WHILE PENALTY, WHEN CHARGED, IS ONLY $5.00, EVERY ITEM should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Child of Jno + Mary McBride

Spec.—8-24-14—M. & T.—2000 Bks.

252579

HEALTH DEPARTMENT—CITY OF BALTIMORE

252579

CERTIFICATE OF DEATH.

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 Orleans St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant McBride

(Residence in Baltimore: No. 1317 West St.; ....yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 2, 1921 (Month) (Day) (Year)

7-AGE, (Premature birth) ....yrs.....mos.....ds. If LESS than 1 day, 5 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....X.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John McBride

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Hewett

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George J. Ruth

(Address) 1735 Hereford ave.

15-

FILED APR 4 - 1921 191.....

ROBERT I. KRAUSE
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 2, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 2 1921, to April 2 1921, that I saw h.. alive on April 2 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion Premature birth 7 months

Frequency (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) John F. Manger M. D.

April 3, 1921 (Address) 1002 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, April 3., 1921

20-UNDERTAKER George J. Ruth — ADDRESS 1735 Hereford ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Pks.

Charles N. Fowler

D 52580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 52580

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 W Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles N. Fowler

(Residence in Baltimore: No. 616 W Saratoga St.; 38 yrs., 1 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, Feb 20, 1883
(Month) (Day) (Year)

7-AGE, 38 yrs. 1 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer): Delivery Store

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Leonard Fowler.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Alsop

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara V. Fowler

(Address) 616 W. Saratoga St.

15- Filed APR 4 - 1921, 191.. ROBERT B. BRUCE Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 1st, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1921, to Apl 1st 1921, that I saw h.im alive on March 27 1921., and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Cavernous

Pneumothorax (Duration) ....yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) N. Dropsy, ...

..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) Edward Gallagher M. D.

Apl 3, 1921. (Address) 1329 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Apr. 4, 1921

20-UNDERTAKER Samuel Wensley ADDRESS 378 W Baltimore St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52581

CERTIFICATE OF DEATH.

151 D 52581

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 N. Belnord ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis G. Meisel

(a) RESIDENCE. No. 629 N. Belnord ST.. 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 days

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May. 2/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				17 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Andrew J. Meisel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Andrew J. Meisel
(Address) 629 N. Belnord

APR 4 - 1921 ROBERT I. FRANKLIN Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-3- 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-2- 1921, to 4-3 1921

that I last saw him alive on 4-2-21 1921.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Primary)
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No findings

What test confirmed diagnosis?

(Signed) F. Fred Klingdal, M. D.

4-3 1921 (Address) 100 N. Bolton St. KHK

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 4 1921

20 UNDERTAKER ADDRESS

William G. Schaeffer 1816 Vermont

N. B.—All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Colburn

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 52582 151 D 52582

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 S Schroeder ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis J. Calburn

(a) RESIDENCE. NO. 113 S Schroeder ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Allan J. Calburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary E. Darby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs M. Calburn (Address) 113 S. Schroeder St.

15 Filed APR 4 - 1921 ROBERT A. KRAUTH Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to April 3, 1921, that I last saw h[illegible] alive on April 2, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Mal-Nutrition

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. C. L. Campbell, M. D.

4/3. 1921 (Address) 1647 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	4/6/1921

20 UNDERTAKER James Dignan & Son ADDRESS 1001 S Paca St

N. B.—MARRIED WOMEN should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52583 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52583

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3410 Elliott St. ST.; 26 WARD)

2-FULL NAME George Richard Wachter

(a) RESIDENCE. NO. 3410 Elliott St. ST., 26 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 13-1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work attended school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER George Wachter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Anna M. Doelfel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant George Wachter (Address) 3410 Elliott St.

15 FILED APR 4 - 1921 BOBERT A KRAUSER Registrar

Burial Permit 01000

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/30/21, 19....., to 3/31/21, 19....., that I last saw h[illegible] alive on 3/31/21, 19....., and that death occurred, on the date stated above, at 5.25 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumococcus peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis?

(Signed) J. H. McGarrell M. D.

(Address) 633-5-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	April 4 1921
20 UNDERTAKER Lilly & Zeiler.	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52584

CERTIFICATE OF DEATH.

50

D 52584

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome A Cox

(a) RESIDENCE NO. Preston Md ST., WARD. Preston Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian R. Cox

6 DATE OF BIRTH (month, day, and year) January 30, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER William A. Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Winnie Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jerome R Cox

(Address) Preston, Md

15 Filed APR4-1921 MURRAY & KRAMER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1921, to April 4, 1921, that I last saw him alive on April 4, 1921, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Diabetic Gangrene R foot.

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

.....(duration) .....yrs. ...mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Cyrus F. Adkins, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Preston, Maryland	4/4/21
20 UNDERTAKER	ADDRESS
W J Tickner & Sons	Natl Pa Ave

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52585 ✓ D 52585

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3444 Reisterstown Road ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Virginia Chauncey

(Residence in Baltimore: No. 3444 Reisterstown Road St.; 61 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FIGURES should be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, March, (Month) 5, (Day) 1860, (Year)

7-AGE, 61 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... no Trade
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Chauncey

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C. Ens

(Address) 3444 Reisterstown Rd.

15- Filed APR 4 - 1921, 191.....

ROBERT J. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Year 1919, to April 1 1921, that I saw her alive on March 31 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cedema Pulmonum

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Interstitial nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) A. H. A. Mayer M. D.

IV. 2, 1921 (Address) 2438 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem — DATE OF BURIAL, April 4, 1921

20-UNDERTAKER Wm J. Ricker & Sons — ADDRESS North & Pa

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52586

CERTIFICATE OF DEATH.

89 D 52586

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3716 Barrington Road ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wharton Brown Jr

(a) RESIDENCE. No. 3716 Barrington Rd ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 20 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles W Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary V Garrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Chas W Brown (Address) 3716 Barrington Rd

15 Filed APR 4 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/21 19

17 I HEREBY CERTIFY, That I attended deceased from 4/1/21, 19, to 4/3/21, 19, that I last saw h[illegible] alive on 4/2/21, 19, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) H. Hoard, M. D.

4/3/21, 19 (Address) 409 Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 19 24
20 UNDERTAKER	ADDRESS
W. P. Townsend Son	Monte

N. B.—WHITE PAPER. PRINT. PLAIN TYPE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52587 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 52587

79

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2010 N. Calvert St.: 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Jane Griffith

(a) RESIDENCE. No. 2010 N. Calvert St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Robt. H. Griffith

6 DATE OF BIRTH (month, day, and year) Sept 8th 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward L. LeCompte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER Emily Dawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Md

14 Informant Virginia A. Wilson

(Address) 2010 N. Calvert St.

15 Filed . 19 ~~DEATH~~ CERTIFICATE Registrar

APR4-1921 Burial Permit Oleo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1921

17

I HEREBY CERTIFY, That I attended deceased from ....., 1916, to Apr. 2, 1921.

that I last saw her alive on March 28, 1921.

and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

5 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar R. Stroebel M. D.

. 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	April 4 1921

20 UNDERTAKER ADDRESS

John O. Mitchell 1201 W. Fayette St.

N. B.—BLANKS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52588

CERTIFICATE OF DEATH.

79 D 52588

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dryden

(a) RESIDENCE. No. 434 Wellington Lane ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Samuel Dryden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore, Maryland

12 MAIDEN NAME OF MOTHER Mary McCullough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed APR 4 - 1921 ROBERT J. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1921, to April 1, 1921.

that I last saw him alive on April 1, 1921.

and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) B. H. Seaman, M. D.

4/2/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery DATE OF BURIAL 4 Apr 1921

20 UNDERTAKER H. Sanders & Son ADDRESS 1710 Eden

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 D 52589

REGISTERED NO.....

1-PLACE OF DEATH Union Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 514 Division ST.: 13 WARD)

2-FULL NAME Gabriel M. Zackerman

(a) RESIDENCE. No. 2228 Callow Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all his life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Gabriel M Zackerman

6 DATE OF BIRTH (month, day, and year) July 1 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Zackerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Wexler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address) [illegible]

15 Filed APR 4 - 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch. 22, 1921, to Apr. 3, 1921, that I last saw h[illegible] alive on Apr. 3, 1921, and that death occurred, on the date stated above, at 5.06 P. m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma of Sigmoid (duration) About two mos.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 3/28/21.

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) J. A. Blackford M. D.

4/3, 1921 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balt Hebrew	April 5 1921

20 UNDERTAKER H. Lavin & Sondheim ADDRESS 1107 N. Mt Royal

N. B.—ENTRIES must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--6-9-19--H. P. Co.--1000 Bks.

D 52590

HEALTH DEPARTMENT—CITY OF BALTIMORE

150

D 52590

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 N. Luzerne ave., ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audry Naomi Thrift

(a) RESIDENCE. No. 503 N. Luzern ave., ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 31-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Cornelius F. Thrift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Cornelius F. Thrift

(Address) 503 N. Luzerne ave.

15 Filed APR 4 - 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17

I HEREBY CERTIFY, That I attended deceased from Mch. 31. 1921. to April 3. 1921.

that I last saw her alive on April 3 1921.

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Condition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) C. Lamm M. D.

Apl. 4 1921 (Address) 1215 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Solomons Md.	Apr. 4 1921
20 UNDERTAKER	ADDRESS
Wm. E. Black	927 N. Broadway

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should give information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52591

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH 1, 52591

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Cordus

(a) RESIDENCE. NO. 3739 Mt. Pleasant Ave. ST.. WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Henry Cordus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed APR4-1921 16 Registered

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1921, to March 30, 1921.

that I last saw him alive on March 30, 1921.

and that death occurred, on the date stated above, at 7:40 P.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.
(No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) B Steinman, M. D.

3/31/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 4 - 1921

Commissioner Health.

per Wm. E. WOODALL

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52592

CERTIFICATE OF DEATH.

37

D 52592

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Johnson

(a) RESIDENCE. No. 721 W. Franklin St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary L. Johnson

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed APR4-1921 19 Registrar

ROBERT I KRAUTER
Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1917, to March 31, 1921, that I last saw him alive on March 30, 1921, and that death occurred, on the date stated above, at 6:40 A. m.

The CAUSE OF DEATH* was as follows:

Tabes dorsalis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann.

(Signed) R. H. Levman, M. D.

3-31-21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: APR 4- 1921

20 UNDERTAKER

ADDRESS

Commissioner Health.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52593

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 716 Mura ST.: 10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M Gilooly

(a) RESIDENCE. No. 716 Mura ST.: ..... WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 27 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Gilooly

6 DATE OF BIRTH (month, day, and year) May 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Lowland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Garraghty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Michael Gilooly

(Address) 716 Mura St

Filed APR 4 - 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1921

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1921, to April 2, 1921, that I last saw him alive on April 2, 1921, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) dilated heart

(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

(Address) 700 Clem St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Apr. 5 1921

20 UNDERTAKER: H C Wiedefeld — ADDRESS: 914 Drumm

WHITE LEAFLET, carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

52594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 D 52594

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 N. Calvert St. 12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary T. Bode.

(a) RESIDENCE. No. 1829 N. Calvert. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Detrick Bode, 2

6 DATE OF BIRTH (month, day, and year) Aug 7th 18

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Denis Burgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER — Delaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Patrick Bode, (Address) 1829 N. Calvert St.

15 Filed APR 4 - 1921 19 [illegible] Registrar. Burial Permit Ojer.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1921, to April 2, 1921, that I last saw her alive on Apr. 1, 1921, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J M Delevett, M. D.

(Address) 621 Columbia Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Apr. 5th 1921
20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr. Jos. M. Delevett 621 Columbia Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 52595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60 D 52595

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 340 Hilton St.; 16 WARD)

2-FULL NAME Mr Geo R Bobb

(Residence in Baltimore: No. 340 Hilton St.; 38 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April March 27, 1866 (Month) (Day) (Year)

7-AGE, 54 yrs. 11 mos. 4 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Manager
(b) General nature of industry, business, or establishment in which employed (or employer): Telegraph Co.

9-BIRTHPLACE, (State or Country) Pa

PARENTS.

10-NAME OF FATHER, John G Bobb

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Emma Eckel

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A F Lorraine Bobb

(Address) 340 Hilton

15- APR 4 - 1921 ROBERT F KRAUTH

Filed ....., 191... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1921, to March 31 1921, that I saw h... alive on March 31 1921, and that death occurred, on the date stated above, at 4.50 P.M.

The CAUSE OF DEATH* was as follows:

Abscess L Ovarian

.....

.....

..... (Duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Mass Pharyngeal Catarrh (Duration) 10 yrs. ... mos. ... ds.

(Signed) John A Cain M. D.

....., 191... (Address) 101 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, April 4, 1921

20-UNDERTAKER H M Rowlson

ADDRESS 230 N Greene

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52596

CERTIFICATE OF DEATH.

91 D 52596

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 Carroll St. 21 Ward)

2-FULL NAME Marie Kath. Lueckert

(a) RESIDENCE. No. 1106 Carroll St., 21 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 27 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Geo Wm Lueckert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: M Knapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Geo W Lueckert 1106 Carroll St

15 Filed APR 4 - 1921 ROBERT B KNOTTS Registrar

Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 2 1921 to Apr 3 1921, that I last saw h[illegible] alive on Apr 3 1921, and that death occurred, on the date stated above, at 10:40 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John C Schwarzenberg M. D.

, 19 (Address) 1120 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	April 4 1921
20 UNDERTAKER	ADDRESS
Geo Lemlech & Son	647 N Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other infection

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52597

CERTIFICATE OF DEATH.

79 D 52597

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1005 Ridgely ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian R. Korb

(Residence in Baltimore: No. 1005 Ridgely St. St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) single

6-DATE OF BIRTH, Nov. (Month) 28. (Day) 1900 (Year)

7-AGE, 20 yrs. 4 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Gustavus A. Korb

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Minnie A. Pfeil

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Minnie A. Korb

(Address) 1005 Ridgely St.

15-

Filed APR4-1921, 19... [illegible] Burial Permit Issued

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 1st. (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr. 1st 1921, to April 1st 1921, that I saw h[illegible] alive on April 2nd. 1921, and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Dropsy and Oedema of Lungs

(Duration) ....yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Insufficiency of Mitral Valve (Rheumatic)

(Duration) 2 yrs. — mos. — ds.

(Signed) C. J. Lebold M. D.

April 2nd, 1921. (Address) 1101 Linganth St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, April 4, 1921

20-UNDERTAKER Geo Leinbach & Son

ADDRESS 647 N Bath St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52598

CERTIFICATE OF DEATH.

120 D 52598

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Neal

(a) RESIDENCE. No. 421 W. Monument St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	~~56~~ 51 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co., Maryland

PARENTS

10 NAME OF FATHER Henry Carberry

11 BIRTHPLACE OF FATHER (city or town) St.Mary's Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) St.Mary's Co. (State or country) Maryland

14 Informant Hospital Records,
(Address) New City Hospital.

15 APR4-1921 ROBERT B. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1921, to April 1, 1921.
that I last saw her alive on April 1, 1921.
and that death occurred, on the date stated above, at 9:30 A. m.
The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency duration yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes. What test confirmed diagnosis? Yes special test.

(Signed) R Herman M. D.

4/1/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Gem	April 5 1921
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Ca ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52599

CERTIFICATE OF DEATH.

37 D 52599

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 721 Dover St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Gardner

(a) RESIDENCE. No. 721 Dover St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ella Cornish

(Address) 721 Dover St

15 Filed APR 4 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 16, 1921, to April 1, 1921, that I last saw her alive on March 1, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Terminal apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wesley A Young, M. D.

4/3, 1921 (Address) 729 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 3 21
20 UNDERTAKER	ADDRESS 916
Daniel Easter	Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lues

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52600

CERTIFICATE OF DEATH.

66 D 52600

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 S. Bouldin ST.: 26 WARD)

2-FULL NAME Susie J. Cannon

(a) RESIDENCE. No. 1010 S. Bouldin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel J. Cannon

6 DATE OF BIRTH (month, day, and year) Apr. 25-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co., (State or country) Md

PARENTS

10 NAME OF FATHER George Simmons

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co. (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Allen

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co. (State or country) Md.

14 Informant Edward Cannon
(Address) 1010 S. Bouldin St.

15 Filed APR 4 - 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 3 1, 1921, to Apr 3, 1921, that I last saw h[illegible] alive on Apr 3, 1921, and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia

2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

4/4, 1921 (Signed) Leo Karlinsky, M. D. (Address) 3035 Donnell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	April 6 1921
20 UNDERTAKER	ADDRESS
Zirkler & Zirkler	1739 E. Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52601

CERTIFICATE OF DEATH.

28 D 52601

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 Barnes ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norbert Svec

(a) RESIDENCE. No. 1633 Barnes ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Svec

6 DATE OF BIRTH (month, day, and year) April 6, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Svec

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Kvatek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Sophia Svec (Address) 1633 Barnes. str.

15 Filed APR 4 - 1921 Robert I. [illegible] Registrar

Burial Permit Oiled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1921, to April 3, 1921, that I last saw h[illegible] alive on April 2, 1921, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

1) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. J. Gary, M. D.

April 5, 1921 (Address) 677 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 5 1921
20 UNDERTAKER	ADDRESS
Fickler & Fickler	1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52602

28

D 52602

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 453 Orchard St ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David McDaniel

(a) RESIDENCE. No. 453 Orchard St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 10, 1905

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Randolph McDaniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lottie Bullard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lottie S. McDaniels

(Address) 453 Orchard St.

15 APR4-1921 [redacted] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3-1921

17 I HEREBY CERTIFY, That I attended deceased from March 25 1921, to April 3, 1921, that I last saw him alive on April 3, 1921, and that death occurred, on the date stated above, at 3.25 A m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lung

Tuberculosis of Lung

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lung, (duration) yrs. 3 mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. W. Kennard, M. D.

4-4 1924 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	April 5 1921
20 UNDERTAKER	ADDRESS 1234
John M. Johnson	Etting St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 52603

CERTIFICATE OF DEATH

D 52603

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3927 Frisby ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Imogene W. Mullikland

(Residence in Baltimore: No. 3927 Frisby St. 58 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	widowed

6-DATE OF BIRTH Feby. (Month) 26 (Day) 1835 (Year)

7-AGE 86 yrs. 1 mos. 8 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country) Baltimore, Md

PARENTS

10-NAME OF FATHER John Webb

11-BIRTHPLACE OF FATHER (State or country) Pennsylvania

12-MAIDEN NAME OF MOTHER Ann Leslie

13-BIRTHPLACE OF MOTHER (State or country) Virginia

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Mullikland

(Address) 3927 Frisby St.

15 APR4-1925 Filed ..... 191 ROBERT B. [illegible] Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April (Month) 3, (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31, 1921, to, April 3, 1921, that I saw her alive on April 2, 1921, and that death occurred, on the date stated above, at 12 N

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs ..... mos. 4 ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) C. D. Steenken M. D.

April 4 1921 [Address] 3949 Greenmount Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cpsub. DATE OF BURIAL: 4 1921

20-UNDERTAKER: Geo. A. Little ADDRESS: 2700 Edmondson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52604 ✓

D 52604

X28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME S. Frazer Corkran

(a) RESIDENCE. NO. Lutherville Md. WARD Lutherville Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia B Corkran

6 DATE OF BIRTH (month, day, and year) April 23-1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Penna. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lutherville Md

PARENTS

10 NAME OF FATHER Montgomery B. Corkran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen B. Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Montgomery B. Corkran

(Address) Lutherville, Md.

15 Filed ....., 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

R4-1921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... PATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1921

17

I HEREBY CERTIFY, That I attended deceased from 2/26, 1921, to 4/4, 1921, that I last saw him alive on 4/4, 1921, and that death occurred, on the date stated above, at 1.200 m.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis of liver and coecum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? Yes Date of Mar. 4, 21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M. S. Frazer Dunspaugh, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Towson Md	April 6/1921 19

20 UNDERTAKER Chas. E. Franck ADDRESS 802 Madison Av

Spec.—8-24-14—M. & T.—2000 Bks.

D 52605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 52605

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 South Hanover ST.; 22 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lennie Hardman

(Residence in Baltimore: No. 722 S. Hanover St. 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, March 29, 1874
(Month) (Day) (Year)

7-AGE, 47 yrs. 6 mos. 6 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, Fletcher Dixon

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md

12-MAIDEN NAME OF MOTHER Anna Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Grace Clark

(Address) 1913 Druid Hill Ave

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

APR 4-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 4th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 11th 1921, to April 4 1921, that I saw her alive on April 2nd 1921, and that death occurred, on the date stated above, at 4.30 Am.

The CAUSE OF DEATH* was as follows:

Brights Disease

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. E. Campbell M. D.

April 4, 1921. (Address) 1369 N Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Calvert Co Md

DATE OF BURIAL, April 5, 191..

20-UNDERTAKER J. L. Brown and Son

ADDRESS 108 N Monty Parkers Wharf Calvert Co Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52606

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 524 Burgundy alley ST.: 22 79 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Curtis

(Residence in Baltimore: No. 524 Burgundy alley (St.: 32 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored	Single

6-DATE OF BIRTH, ... Dont Know ..... (Month), 1 ..... (Day) (Year)

7-AGE, 48 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, John Curtis

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Kitty Crosser

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Reed

(Address) 524 Burgundy alley

15- Robert P. Harrison,

Filed APR 4-1921, 191.....

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April 1st ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said..... (~~Inquest, au-~~ ~~topsy or~~ inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know of any

(Duration) yrs. mos. ds.

(Signed) W. K. Gorsuch M. D.
(Coroner.)

April 2, 1921 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn St	April 5, 1921
20-UNDERTAKER, L. G. Brown & Sons	ADDRESS 517 W. Monty St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52607 + 28 D 52607

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Green (Laura Carter)

(a) RESIDENCE. NO. 404 Worsley st. ST.... WARD. Gloucester Co. Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown 8 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of 1896

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 870

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer Lives in Bell- Somerville

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Susie Boothe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address) M. T. H.

15 Filed ..., 19... Robert P. Harrison, Registrar

APR 4 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to April 2, 1921, that I last saw her alive on April 1, 1921, and that death occurred, on the date stated above, at 2.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous broncho-pneumonia (duration) ... yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray.

(Signed) G. C. Medairy, M. D.

4-2-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Allmond Ward Va	April 6- 1921
20 UNDERTAKER Gloster Co	ADDRESS 1725
Mrs Robert A Elliott	Ashland Va

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement may be TION is very important. See instructions on back of certificates.

D 52608 HEALTH DEPARTMENT--CITY OF BALTIMORE ✓ D 52608

CERTIFICATE OF DEATH

92

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 704 East Monument St 10 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Colbert

(Residence in Baltimore: No. 704 E. Monument St St.: yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male

4-COLOR OR RACE Col

5-SINGLE, ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)

6-DATE OF BIRTH May 4th (Month) (Day), 1920 (Year)

7-AGE ..... yrs. 11 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) Infant - Son

9-BIRTHPLACE (State or country) born in Baltimore Md.

PARENTS

10-NAME OF FATHER George Colbert

11-BIRTHPLACE OF FATHER (State or country) Annapolis Md.

12-MAIDEN NAME OF MOTHER Fannie James

13-BIRTHPLACE OF MOTHER (State or country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fannie Colbert

(Address) 704 E Monument St

15-

Filed ..... 19.. Robert P. Harrison, REGISTRAR

APR 4 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April 3rd (Month) (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from March 31st, 1921, to April 3 1921.

that I saw him alive on April 3rd, 1921.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. J. Morgan M. D.

4/4/21, 191 (Address) 6 North Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Laurel Cemetery — DATE OF BURIAL April 6 1921

20-UNDERTAKER Wm Robert A Elliott — ADDRESS 1725 Eshland Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52609

CERTIFICATE OF DEATH.

92 D 52609

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 45 Hillsamson ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Connors.

(a) RESIDENCE. No. 45 Hillsamson ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret Connors

6 DATE OF BIRTH (month, day, and year) Aug 31, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	7	1	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) O.D.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Bernard Connors

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Connors (Address) 45 Williamson St

15 Filed APR 4 - 1921 Robert P. Harrison, Registrar

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 1 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to Apr. 1, 1921, that I last saw him alive on Apr. 1, 1921, and that death occurred, on the date stated above, at 3:05 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? .....

What test confirmed diagnosis? —

(Signed) F. Edw. Smith M. D.

, 19 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Apr 5 1921
20 UNDERTAKER Margaret A. Flynn	ADDRESS 1402 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52610

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 52610

96
34

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1307 Andre ST. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary M. Scharfer

(Residence in Baltimore: No. 1307 andre Av ST.; life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH May (Month) 4 (Day), 1854 (Year)

7 AGE 66 yrs. 10 mos. 29 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Sies

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary M Hughes

(Address) 1307 Andre St

15 Robert P. Harrison, REGISTRAR

Filed ....., 191.....

Burial Permit [redacted]

APR 4 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 2 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1921, to April 2 1921, that I saw h[illegible] alive on Apr 1, 1921, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Acute Dilatation of Heart.

(Duration) ..... yrs. ..... mos. 4 hrs.

(Signed) Thos F. Stevens M. D.

Apr 2, 1921 (Address) 2866 Kenyon Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Balto. Cem

DATE OF BURIAL Apr. 5, 1921

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1422 Eighth St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52611

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52611

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Baird

(a) RESIDENCE. No. US. Public Health Hosp. #56 St. Baltimore Md. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) ---

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27 yrs,	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer -- --

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rambeck Registrar
(Address) US. PHS Hosp. #56 Ft McHenry Md

15 Filed APR 4 1921 19 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1921, to April 2, 1921, that I last saw him alive on April 2, 1921, and that death occurred, on the date stated above, at 7.45 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary active.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Thomas B. Payne, M. D.
Senior Surgeon (R)

, 19 (Address) US. PHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philia Pa	April 4 1921
20 UNDERTAKER S. Lunson	ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52612

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST.: 20 WARD)

2-FULL NAME Sarah Craig.

(a) RESIDENCE. No. 308 N. Pulaski ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Edward Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Wynn

(Address) 1959 W. Fayette St.

15 Filed APR 4-1921 Albert E. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1921, to April 4, 1921, that I last saw him alive on April 4, 1921, and that death occurred, on the date stated above, at 1.25 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	April 6 1921
20 UNDERTAKER	ADDRESS
Martin Fisher's Sons	1827 N. Howard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52613 ✓ D 52613

CERTIFICATE OF DEATH.

152

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1365 Whatcoat ST. 15 WARD)

2-FULL NAME Baby Jacker

(a) RESIDENCE. NO. 1365 Whatcoat ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

should be stated EXACTLY. PHYSICIANS should state
it may be properly classified. Exact statement of OCCUPA-
on back of certificates.
TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3-1921

7 AGE	Years	Months	Days	If LESS than 1 day 20 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ood

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Wesley Jacker

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Bella Adams

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Bella Jacker Mother
(Address) 1365 Whatcoat St

15 Filed APR 4 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1921, to April 3, 1921

that I last saw h[illegible] alive on April 3, 1921,

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allons Reese, M. D.

4-4, 1921 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W-Fairview	Apr 6 1921
20 UNDERTAKER	ADDRESS
Wm H. Glass Sons	1400 Mosher

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52614

CERTIFICATE OF DEATH.

D 52614

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 N. Carey ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Curry

(Residence in Baltimore: No. 1031 N. Carey St.; yrs. 11 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem	Col	

6-DATE OF BIRTH, April (Month) 26 (Day), 1920 (Year)

7-AGE, ...yrs. 11 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, Wm A. Curry

11-BIRTHPLACE OF FATHER (State or Country), N. Y. Va ?

12-MAIDEN NAME OF MOTHER Pearl E. Hagney

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm A. Curry

(Address) 1031 N. Carey St

15- APR 4 - 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 4th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 26th 1921, to April 3rd 1921, that I saw her alive on April 3rd 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

(a) Bronchopneumonia

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Geo. W. Fauteux Jr. M. D.

April 4th, 1921 (Address) 2215 N. Mark. ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, April 6, 1921

20-UNDERTAKER Wm. H. Horse Sons ADDRESS 1403 Mosher

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

(Rosie M. Simms)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52615

D 52615

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 711 Ireland ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie M Simms

(a) RESIDENCE. No. 711 Ireland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George A Simms

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE — Years: 50 — Months — Days — If LESS than 1 day, ..hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md. Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: George E. Simms (Address) 711 Ireland St

15 Filed APR 4-1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2 1921

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to April 2, 1921, that I last saw h[illegible] alive on April 2, 1921, and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH was as follows:

Cardiac Disease Valvular

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death? 711 Ireland St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) A H Harrison M. D.

April 4. 1921 (Address) 712 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MT Auburn — DATE OF BURIAL: Apr 5th 1921

20 UNDERTAKER: Sam'l H. Chase & Son — ADDRESS: 1401 Madison

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mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52616

CERTIFICATE OF DEATH.

9/ D 52616

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Ellamont ST.: 20 WARD)

2-FULL NAME Maria Taylor

(a) RESIDENCE. No. 108 Ellamont ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Washington Taylor

6 DATE OF BIRTH (month, day, and year) [illegible] 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) J. F. Taylor 108 Ellamont St

15 Filed 19 Robert P. Harrison, Registrar

PR4-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 2, 1921, to Apr 3, 1921, that I last saw h[illegible] alive on Apr 3, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) W. A. Hall, M. D.

4/3, 1921 (Address) Lemington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	April 6 1921

20 UNDERTAKER Edw. W. Pyle

ADDRESS 903 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52617

D 52617

103

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 Folsom ST.: 24 WARD)

2-FULL NAME Edward Schultz Sanford

(a) RESIDENCE. No. 412 Folsom St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 20 - 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William J. Sanford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rock Hall Kent Co

12 MAIDEN NAME OF MOTHER Ida M. Groff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Wm J Sanford (Address) 412 Folsom St

15 Filed Apl 3 1921 Robert P. Harrison, Registrar

APR4-1921 Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3 1921

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1921, to April 3, 1921, that I last saw h— alive on April 3, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(duration) 2 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Dr. Thompson M. D.

4/4/1921 (Address) 5' Gaddis

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apl. 5, 1921
20 UNDERTAKER	ADDRESS
Wm J Luckett Sons	North Ave

Should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52618 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52618

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2503 Shirley av ST.; 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Jane Smith

(Residence in Baltimore: No. 2503 Shirley av St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, April Eleventh, 1848.
(Month) (Day) (Year)

7-AGE, 72 yrs. 11 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country) Pennsylvania

PARENTS.

10-NAME OF FATHER, Geo Dietrich

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Elizabeth Steltzer

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. J. Eby

(Address) 2503 Shirley Ave., Baltimore

15-

Filed APR 4 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 3 - 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 9 1920, to April 3 - 1921, that I saw h[er] alive on April 3 - 1921, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Muscular Paralysis following Cerebral Apoplexy & Left Hemiplegia

about 6 months

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture Right Femur, Liver Pulmonaria

Insanitation (Duration) yrs. about 6 mos. weeks ds.

(Signed) Carlton M. Cook M. D.

April 3, 1921 (Address) 1107 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Philadelphia DATE OF BURIAL, Apr 6 191.

20-UNDERTAKER H. Thomas & Son ADDRESS Rose

Remarks Male Wid - Was Pa. Th. Hosp

Fractured in Bed, When the Nurse West Phila
was helping her to use bed pan.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner.* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Germa)

D 52619 HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 52619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 215 S castle ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E Gums

(a) RESIDENCE. No. 215 S Castle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary D Gums

6 DATE OF BIRTH (month, day, and year) August 4 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer opr d & Mach Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Gums

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Gums (Address) 215 S Castle st

15 Filed APR 4 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 1921

17 I HEREBY CERTIFY, That I attended deceased from January 2, 1921, to March 31, 1921, that I last saw h.. alive on March 31, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Probably

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

, 19 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	April 6 1921
20 UNDERTAKER	ADDRESS
Jas C. Miller	233 E Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52620

91-079

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St., 8 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Simms

(a) RESIDENCE. No. 1817 N Castle St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph C Simms

11 BIRTHPLACE OF FATHER (city or town) Louisiana.
(State or country)

12 MAIDEN NAME OF MOTHER Viola J. Vecchio.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant (Address) Joseph C Simms. 1817 N. Castle St.

15 Filed Robert P. Harrison, Registrar

PR4-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/1921

17 I HEREBY CERTIFY, That I attended deceased from 3/30/1921, to 4/2/1921, that I last saw him alive on 4/2/1921, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Typical signs + Symptoms

(Signed) Chas. O'Donovan, M. D.

, 19 (Address) S. E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 5 1921
20 UNDERTAKER Chas C. Miller	ADDRESS 2336 Jeffer

mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52621 ✓ D 52621

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 S Bond ST. 3 WARD)

2-FULL NAME Joseph Burdelas

(a) RESIDENCE. NO. 822 S Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaus Burdelas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Aleksandra Ostrawska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Stanislaus Burdelas 822 S Bond St

15 Filed ... Robert P. Harrison, Registrar

Burial Permit Clerk.

APR 4 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2 1921, to April 3 1921,
that I last saw him alive on April 3 1921,
and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) John H. Rahlberger, M. D.

19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	19
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

should be stated EXACTLY. PHYSICIAN should state
it may be properly classified. Exact statement of OCCUPA-
on back of certificates.
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back
mation should be carefully supplied. AGE

D 52622

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52622

CERTIFICATE OF DEATH.

REGISTERED No. C. 56

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jozef Marcinko

(Residence in Baltimore: No. 412 E Bond St. (St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug (Month) 19 (Day) 1883 (Year)

7-AGE, 37 yrs. 7 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor 040
(b) General nature of industry, business, or establishment in which employed (or employer): Iacy Foundry

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Stanislaus Marcinko

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Anna Pawelczyk

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kanstanty Marcinka

(Address) 412 E Bond

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 / 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Coroner.)

4/9/21 (Address) 143 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, April 5, 1921

20-UNDERTAKER John M Weber — ADDRESS 1803 Bank

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 4 - 1921

D 52623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2146 Colvin St.: 5 WARD) 9

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt Lewis.

(Residence in Baltimore: No. 2146 Colvin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, November (Month) 28 (Day) 1919 (Year)

7-AGE, ... 1 Yrs. 4 Mos. — Ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), born in Baltimore City

PARENTS.

10-NAME OF FATHER, Kelley Fowlin

11-BIRTHPLACE OF FATHER (State or Country), born in N.C.

12-MAIDEN NAME OF MOTHER Marthia Mitchell

13-BIRTHPLACE OF MOTHER (State or Country), N C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marthia Kelley

(Address) 214 Colvin St

15- APR5-1921 Filed ..... 191.. ROBERT J. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 2 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonia

2 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) G. C. Biddle M. D. (Coroner.)

4/4/21 (Address) 432 E. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, April 5, 1921

20-UNDERTAKER Jno Robert A Elliott

ADDRESS 1725 Lakland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Morgan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52624

CERTIFICATE OF DEATH.

79r D 52624

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 619 n Bond St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William morgan.

(Residence in Baltimore: No. 619 n Bond St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown 11, 1890.
(Month) (Day) (Year)

7-AGE, 31 yrs. ? mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Charleston. S. Carolina

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country). Unknown.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Morgan.

(Address) 619 N. Bond St. B.

15-APR5-1921 ROBERT J. KRAETER

Filed....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 2, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) John Ingley M. D.
(Coroner)

4-2, 191.1. (Address) B. E. Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery. DATE OF BURIAL, April 5, 1921

20-UNDERTAKER Milton Davis 413. N. ADDRESS Eden St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52625

CERTIFICATE OF DEATH.

130 D 52625

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 Weber ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Kern.

(a) RESIDENCE. No. 126 Weber ST.. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Conrad Kern

6 DATE OF BIRTH (month, day, and year) May 3 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Conrad Kern (Address) 126 Weber St

15 APR 5 - 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to April 2 1921

that I last saw her alive on April 2 1921

and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) John H Groshans M. D.

4/4/1921 (Address) 3100 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross (A&C)	4- 5th 1921

20 UNDERTAKER E and B Hale ADDRESS 115 E Westst

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~14-39~~ D 52626 ✓ 1+n+091 D 52626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen C. Compton

(a) RESIDENCE. NO. Brunswick Md ST., WARD. Brunswick Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE~~ of) Carmelita Compton Brunswick Md.

6 DATE OF BIRTH (month, day, and year) Jan 31 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Peter V Compton

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Parmelia Catlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed APR 5 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to April 4, 1921, that I last saw him alive on April 4, 1921, and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows:

Tumor of the brain

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. R. Mason, M. D.

, 19 (Address) Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brunswick Md.	4-5-1921
20 UNDERTAKER	ADDRESS
Earl B Hale	115 E West St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52627

CERTIFICATE OF DEATH.

64 D 52627

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 Eutaw Place ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophie Battee Mullikin

(Residence in Baltimore: No. Lifetime St.; 66 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, December 21, 1854
(Month) (Day) (Year)

7-AGE, 66 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Richard Ridgley Battee

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Caroline E. L. Cochran

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester County Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary H. Mullikin

(Address) 1316 Eutaw Place Baltimore

15- Filed APR 5 - 1921 191... ROBERT I. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 3, 1921, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1919, to April 3 1921, that I saw her alive on 3 day April 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Hemi-plegia

12 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (Duration) 12 yrs. ..... mos. ..... ds.

(Signed) John D. Kerring M. D.

April 4, 1921 (Address) 1425 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Olivet Cem	April 5, 1921
20-UNDERTAKER John D. Mitchell	ADDRESS 1711 Fayette

N.B.—Every item of information should be given as accurately as possible. CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52628

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52628

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Mellor

(a) RESIDENCE. NO. Della Md. ST., WARD. Della Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: 52 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Della Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Mrs. James Mellor Edmondson City, Md.

15 Filed APR 5 - 1921 19 ROBERT I. FRANK Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to April 5, 1921, that I last saw him alive on April 5, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Post febrile Psychosis (duration) yrs. mos. 2 wks

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos. D. Heyer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Della M. E. Cem. DATE OF BURIAL: April 1921

20 UNDERTAKER: Euston Sons ADDRESS: Edmondson City Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 52629

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Ellsworth ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Kucera

(a) RESIDENCE. No. 2006 Ellsworth ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joe. Kucera

6 DATE OF BIRTH (month, day, and year) Feb 28/1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joe Zelasko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Mikum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Francis Hirshauer

(Address) 2006 Ellsworth

15 Filed APR 5 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 3, 1921

that I last saw her alive on April 3, 1921

and that death occurred, on the date stated above, at 10 00 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F Fredk Kundrat, M. D.

4-4, 1924 (Address) 800 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: April 6 1921

20 UNDERTAKER: Geo. M. Fink & Son, — ADDRESS: 811 N Howard

Funeral Directors & Embalmers.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52630 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52630

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St Hospital St.; 16 WARD) REGISTERED No. C 172

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hallman

(Residence in Baltimore: No. 1929 W Lafayette ave St.; yrs., 44 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 44 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Daniel McKenna

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Margaret O'Brien

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Hallman

(Address) 1929 W Lafayette ave

APR 5 - 1921

Filed ....., 191.... Deputy Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH was as follows:*

Fracture Pelvis typhoid Hemorrhage & falling pain wound & Peritonitis Acute

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James W Taylor M. D.
(Coroner.)

4-5, 1921 (Address) 700 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 904 N Fremont ave

Former or usual residence 1929 W Lafayette Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross	Apr 6, 1921

20-UNDERTAKER Martin Fahey - Sons ADDRESS 1827 W Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Martin Fahey - Sons 1827 W Pratt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52631

D 52631

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 917 Edmondson Ave.

REGISTERED NO. 80

CITY OF BALTIMORE: (No. Balto. Md. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry M. Schanbuger

(a) RESIDENCE. No. 917 Edmondson Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? 82 yr. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12 - 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	8	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Shoe Mfr
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Fredk Schanberger
(Address) W Baltimore

15 Filed APR 5 - 1921 16 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to April 6, 1921, that I last saw him alive on April 6, 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

1 month (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac paralysis

1 day (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood pressure stethoscope

(Signed) J. C. Lamps M. D.

, 19 (Address) 954 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Apr 6 1921
20 UNDERTAKER	ADDRESS
Martin Fahey - Sons	1827 W Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

-469

D 52632

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Foot of Covington St at Key Highway ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Harris.(C)

(Residence in Baltimore: No. 1408 E.Lexington St. St.; yrs. 4 mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, January 9th. 1907. , 1 .....
(Month) (Day) (Year)

7-AGE, 14 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), South Carolina.

PARENTS.

10-NAME OF FATHER, Cleophus Harris.(C)

11-BIRTHPLACE OF FATHER (State or Country), South Carolina.

12-MAIDEN NAME OF MOTHER Marie Allen.(C)

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cleophus Harris.(C)father.

(Address) 1408 E.Lexington St.

15- APR5-1921 Filed....., 191.... [illegible] Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Drowned March 27th 1921. Body found floating April 4th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned,
while in swimming.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

April 4, 1921 (Address) 1017 S.Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Md Auburn Cmty | DATE OF BURIAL, Apr. 6, 1921

20-UNDERTAKER George H Holland | ADDRESS 1630 Druid Park Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52633

D 52633

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. North ave Mt Washgtn ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME G. W. Russell George

(Residence in Baltimore: No. North ave Mt Washgtn St.; 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept. (Month) 28 (Day), 1857 (Year)

7-AGE, 63 yrs. 6 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Isaac George

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Mann

13-BIRTHPLACE OF MOTHER (State or Country), Halifax

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac George

(Address) Mt Washington Md.

15-

Filed APR 5 - 1921 [illegible]

[illegible] Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 3 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1920, to Apr. 3 1921, that I saw him alive on Apr. 2 1921, and that death occurred, on the date stated above, at 5.05 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sclerosis followed by Asphyxia by

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Beeten M. D.

4-5, 1921. (Address) Mt Washgtn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Calvary — DATE OF BURIAL, April 5, 1921

20-UNDERTAKER Henry H. Mears Son — ADDRESS 805 N Calvert St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52634

CERTIFICATE OF DEATH.

45D 52634

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 657 W. Barre ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Moore

(a) RESIDENCE. NO. 657 W. Barre ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. c mos. c ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or Divorced (write the word)
Male	white	Widower

5a If married, widowed or divorced, HUSBAND of (or) WIFE of Beatrice Moore

6 DATE OF BIRTH (month, day, and year) April 11 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Amos
(Address) 657 W. Barre st

15 Filed APR 5 - 1921 19 ROBERT J. BRAUTHER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 4. 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16th, 1920, to Apr. 4 1921, that I last saw h.. alive on Apr. 2 1921, and that death occurred, on the date stated above, at 3:A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Posterior Cervical Glands

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Dellell, M. D.
Apr. 4, 1921 (Address) 621 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Harford Road	Apr 7 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	217 S. Bro

AGE should be carefully supplied. All questions should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52635

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital Saratoga & Calvert St.; (Ward) 4 × 107

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. James G. Perry

(a) RESIDENCE. No. Parkton Md. St.. Ward. Parkton Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ada Perry

6 DATE OF BIRTH (month, day, and year) May 19th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
44	"	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ella Loving

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Ada Perry

(Address) Parkton Maryland

15 Filed APR 5 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Oled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 3 - 21 19

17

I HEREBY CERTIFY, That I attended deceased from March 29th 1921, to April 3rd 1921,

that I last saw him alive on April 3rd 1921,

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer,
(General peritonitis.)

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 3/29/21

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) W. F. Martin, M. D.

4/3. 1921 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Moreford Cemetery Balto Co	4/6 1921
20 UNDERTAKER Geo W Little	ADDRESS 2700 Edmondson Av.

WHICH SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52636

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View; 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Ziwiki

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia- Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed . 19 ROBERT R KRAUTH Registrar

APR5-1921 Social Service Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1921. to April 3, 1921. that I last saw h. im alive on April 3, 1921. and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis.
(No cerebral hemorrhage)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann special test

(Signed) [illegible] M. D.

4/4/ 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. Polish Independent	Apr 6" 1921.

20 UNDERTAKER	ADDRESS
M. F. Sadowski,	705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52637

D 52637

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 Reisterstown Rd ST.: 15 WARD)

2-FULL NAME John B. Goodwin Junior

(a) RESIDENCE. NO. 2310 Reisterstown Rd ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Goodwin

6 DATE OF BIRTH (month, day, and year) Jan 14 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer) in ticket office

(c) Name of employer

9 BIRTHPLACE (city or town) Atlanta Ga
(State or country)

PARENTS

10 NAME OF FATHER John B. Goodwin Jr

11 BIRTHPLACE OF FATHER (city or town) Cobb Co.
(State or country) Ga

12 MAIDEN NAME OF MOTHER Emma McAfee

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ga

14 Informant Elizabeth Goodwin
(Address) 2310 Reisterstown Rd

15 APR 5 - 1921 ROBERT B. ERA... Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 3, 1921, to Apr 5, 1921, that I last saw h... alive on Apr 4, 1921, and that death occurred, on the date stated above, at 3 55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
and uraemia
Pulmonary Edema.
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism
(duration) about 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bernard J Lynch, M. D.

4/5, 1921 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	April 6 1921
20 UNDERTAKER	ADDRESS
Jno B Cook	1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52638

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 52638

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 Clifton Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna Phillips (Phillips)

(a) RESIDENCE. No. 1901 Clifton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Goodman

11 BIRTHPLACE OF FATHER (city or town) Carroll Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susanna Goodman

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co
(State or country) Maryland

14 Informant Harry Phillips
(Address) 1901 Clifton Ave.

15 Filed APR 5 - 1921 ROBERT T. HAVEN Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3" 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1916, to April 3, 1921, that I last saw h[illegible] alive on April 2, 1921, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteria-Sclerosis

(duration) 5 yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? none

What test confirmed diagnosis? Usual Symptoms

(Signed) Emile L Wheeler, M. D.

4/4 1921 (Address) 212 Glenmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland, Maryland	Apr 5th 19
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52639

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

D 52639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 138 W. Hill ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Daines

(a) RESIDENCE. No. 138 W. Hill ST., 22 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet Daines

6 DATE OF BIRTH (month, day, and year) Oct 1876

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	44	5	27	— X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Trimmer

(c) Name of employer Curtis Bay

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Catherine Stotler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Harriet Daines (Address) 138 W. Hill St

15 Filed APR 5 - 1921 ROBERT J. KRAUSE Registrar Bacial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/ 19 21

17

I HEREBY CERTIFY, That I attended deceased from 3/20/, 19 21, to 4/4/, 19 21, that I last saw h... alive on 4/3/, 19 21, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation (duration) Abt 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pul. Tbc and Brights disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Ivy Bowley, M. D.

4/4/21 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr 6 1921
20 UNDERTAKER	ADDRESS
John H Toadvine	1423 Hill St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52640

CERTIFICATE OF DEATH.

64 D 52640

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Druid Hill Av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barcel Howard

(a) RESIDENCE. No. 1622 Druid Hill Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ppd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER Race Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER Harriet Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Susa Wilson
(Address) 1622 Druid Hill Av

15 Filed APR5-1921 [illegible]
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1921, to April 4, 1921, that I last saw h[illegible] alive on April 4, 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Duration: yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J. Wheatley, M. D.

4/5, 1921 (Address) 1230 Eutaw Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Apr 5 1921
20 UNDERTAKER: John H. Toadvine	ADDRESS: Ulrich &

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 52641

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 801 N. Lakewood Av ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Fetter

(a) RESIDENCE. No. 801 N. Lakewood St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Fetter

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Charles Fetter

(Address) 801 N. Lakewood Av

15 APR 5 - 1921

[redacted] Registrar

Burial Permit Olc...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to April 2, 1921, that I last saw h[illegible] alive on April 2, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 5 1921
20 UNDERTAKER	ADDRESS
[illegible] & Son	1906 Bond

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52642

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52642

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~E C H Hospital~~ Mercy Hospital St. 6 WARD)

2-FULL NAME George Koether

(Residence in Baltimore: No. 401 N. Milton St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(yrs. 48 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Md

6-DATE OF BIRTH, Feb 12, 1863
(Month) (Day) (Year)

7-AGE, 58 yrs. 2 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Koether

(Address) 406 Park Ave

15- Filed APR 5 - 1921 ROBERT R KLAUTER Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 3, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cystitis Septicaemia
Caused by Accidental wound of hand - Accidentally drove nail in hand
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. Kelly M. D.
(Coroner.)

April 4, 1921 (Address) 1032 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Schwartz Lem. | DATE OF BURIAL, Apl. 6, 1921

20-UNDERTAKER Philip J. Kenny | ADDRESS 3016 Adams

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52643

D 52643

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 S. 11th St. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida E. Schultz

(a) RESIDENCE. No. 30 S. 11th St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced (or) WIFE of Wm R. Schultz

6 DATE OF BIRTH (month, day, and year) Sept 16-70

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Edward Suter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm R. Schultz (Address) 30 S. 11th St.

15 Filed APR 5 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/30, 1921, to 4/3, 1921, that I last saw h-r alive on 4/3, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Ascending Lalonmay Oedema

(duration) yrs. mos. 10 days

CONTRIBUTORY (Secondary) Endocarditis (duration) Bronchitis 5 days yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Snyder, M. D.

4/5, 1921 (Address) 3355 Baltic

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Apl 7 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52644 + 80 D 52644

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Madison ave ST. 14 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice L. Spear

(Residence in Baltimore: No. 1404 Madison Ave St.; ....yrs., 2 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, March 26, 1856
(Month) (Day) (Year)

7-AGE, 66 yrs. ....mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE, (State or Country) Woodbine Md.

PARENTS.

10-NAME OF FATHER, ? Unknown

11-BIRTHPLACE OF FATHER (State or Country), ? Unknown

12-MAIDEN NAME OF MOTHER Carrie Carter

13-BIRTHPLACE OF MOTHER (State or Country), ? Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. L. Spear

(Address) 306 Watter

15-

Filed APR 5 - 1921 191.... ROBERT J. SLATER Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~March~~ April 4, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 7 - 1921, to April 4th 1921, that I saw her alive on April 2nd 1921, and that death occurred, on the date stated above, at 7.45a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

.....

..... (Duration) ....yrs. 8 mos. ....ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) T. W. Phillips M. D.

4-4, 1921. (Address) 2300 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State life yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Baltimore

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	April 6 1921
20-UNDERTAKER	ADDRESS
James Hayes	1407 Madison ave

N.B. Every item of information should be given as correctly as possible, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Connor

HEALTH DEPARTMENT—CITY OF BALTIMORE

147229
D 52645

D 52645

CERTIFICATE OF DEATH.

+ 13
2

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary L Connor.

(a) RESIDENCE. No. 1328 Wash St Charleston W Va. ST. WARD. W. Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of m G. W. Connor St Albans W Va.

6 DATE OF BIRTH (month, day, and year) October 18 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	2	12	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Teacher 68

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Alex Hopkins.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Edith Kyle.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) J. Hopkins Hosp. Md.

15 APR 5 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1921, to April 4, 1921.

that I last saw h Er alive on April 4, 1921.

and that death occurred, on the date stated above, at 1145 a.m.

The CAUSE OF DEATH* was as follows: Chronic Hypertrophic Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood findings

(Signed) Edward C. Davidson, M. D.

4-4, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Albans, W. Va. DATE OF BURIAL: Apr. 5 1921

20 UNDERTAKER: Samuel Hensley ADDRESS 378 N Bdle

mation should be carefully supplied. AGE should be stated EXACTLY. Particulars should be given CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52646

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 52646

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerry Gale

(a) RESIDENCE. No. 403 N Prine ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1868.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 04D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Zedie Gale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rhoda Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Records City Hospital, Bay View

15 APR 5 — 1921 [illegible] Registrar

Burial Permit Clerk

APR 5 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 28 1921, to April 2, 1921,

that I last saw him alive on April 2, 1921,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Miliary tuberculosis, generalized (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) B B Herman M. D.

April 3, 1921 (Address) City Hospital, Bay View.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Auburn Cem Apr. 5 1921

20 UNDERTAKER — ADDRESS

Samuel A Ramsburg W Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 52647

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 W. Read. ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Frances Persons.

(a) RESIDENCE. No. 8 W. Read ST., 11 WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of ~~(or)~~ WIFE of Rennus Charles Persons U.S.N.

6 DATE OF BIRTH (month, day, and year) 1854?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67?	(	(	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Auburn Alabama

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Barnett (State or country) Alabama

12 MAIDEN NAME OF MOTHER do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) alabama

14 Informant Sidney Morgan Henry (Address) 8 W. Read St.

15 Filed ....., 19.... Registrar

APR 5 - 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1921, to April 4, 1921, that I last saw her alive on April 4, 1921, and that death occurred, on the date stated above, at 7-05 P. m.

The CAUSE OF DEATH* was as follows:

Acetone poisoning.
Diabetic Coma
Length of time Diabetic present unknown, (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Minor Infection for week before death (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sugar in urine.

(Signed) W. Gibson Porter, M. D.

4/5. 1921 (Address) 422 Roland Ave. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn Alabama	4-5 1921
20 UNDERTAKER Henry J. Jenkins Funeral Home Co	ADDRESS McCulloh & Orchard

mation should be carefully supplied. AGE should be stated in years, and fractions of a year or month. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks. Calman Frantz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52648 ✓ D 52648

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 15 WARD) 1 20

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Frantz

(Residence in Baltimore: No. 3430 Reisterstown Rd. St.; ..... yrs., ... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 24, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Boris Frantz

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Kate Pearlman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Baltimore St

15- APR 5 - 1921 Filed ..... 191.... ROBERT P. LAMUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 4, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 21, 1921, to Apr. 4, 1921, that I saw him alive on Apr. 4, 1921, and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Absence of buttock

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Septicemia

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) A. Kaplan M. D.

Apr. 4, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 14 ds. In the State ..... yrs. ..... mos. 14 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rodeph

DATE OF BURIAL, 4-5-21

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt St

N. B. EVERY ITEM must be answered in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 16 WARD) REGISTERED NO. 146

2-FULL NAME Morris Miller

(a) RESIDENCE. No. 1021 W. Lanvale ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 5 mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 24, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy (none)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Morris Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Goldberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Connecticut

14 Informant Jack Lewis
(Address) 1411 E Balto St

15 Filed APR 5 - 1921 ROBERT B. KRAUTZ Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/3, 1921, to 4/5, 1921, that I last saw him alive on 4/5, 1921, and that death occurred, on the date stated above, at 10.40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Osteo-Myelitis of left Femur. (over)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Septic Nephritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/4/21

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Irvin D. Rody M. D.

4/5, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Southern Ave	4/6 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Peritonitis from
Abscess under left
femur opened and
drained on April 4, 1921.
Cause unknown.

Spec.—6-9-19—H. P. Co.—1000 Bks.

52650

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 52650

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Scott St. ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Buschking

(a) RESIDENCE. No. 611 Scott ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Buschking.

6 DATE OF BIRTH (month, day, and year) Dec. 17 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER — Eilerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Buschking

(Address) 611 Scott St

15 APR5-1921 [illegible] Registrar

Burial Family Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1921, to April 3, 1921, that I last saw h[illegible] alive on April 2, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Apoplexy.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/4, 1921 (Address) 729 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	Apr 5 1921

20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Holabird

D 52651

CERTIFICATE OF DEATH.

79 D 52651

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Aliceana ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elizabeth Holabird

(Residence in Baltimore: No. 1427 Aliceana St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Nov 27, (Month) (Day) 1875 (Year)

7-AGE, 45 yrs. 5 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Conrad Eberline

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Gruber

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Wm Holabird

(Address) 1421 Aliceana St.

15- Filed APR 5 - 1921, 191.. ROBERT I. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 2, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1921, to Apr 2 1921, that I saw her alive on Mar 2 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ....yrs. 2 mos. ....ds.

(Signed) John H. Linthicum M. D.

Apr 5, 1921 (Address) 3104 Hanford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cremated Loudon Park — DATE OF BURIAL, April 5, 191.1.

20-UNDERTAKER Leo Leimbach — ADDRESS 647 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52652

CERTIFICATE OF DEATH.

104 D 52652

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2528 N. Calvert ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Charles Cook

(a) RESIDENCE. No. 2528 N. Calvert ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Oct. 27, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Eben Cogswell Cook

11 BIRTHPLACE OF FATHER (city or town) Hampton
(State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Clara E. McNeill

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Clara E. Cook
(Address) 2528 N. Calvert Street

15 Filed APR 5 - 1921 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/21 19

17 I HEREBY CERTIFY, That I attended deceased from April 2nd, 1921, to April 4th, 1921, that I last saw h[illegible] alive on April 4th, 1921, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) 12 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Intoxication (predisposing Cause)

(duration) 96 hours yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. H. Lockwood, M. D.

19 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	4/5, 1921
20 UNDERTAKER	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52653 ✓ D 52653

CERTIFICATE OF DEATH.

Registered No. C 479

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 506 W Fayette St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Maffitt

(Residence in Baltimore: No. 506 W Fayette St.; yrs. 83 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec 15, 1848 (Month) (Day) (Year)

7-AGE, 83 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sophia Talbott

(Address) 506 W. Fayette St.

15- Filed APR 5 - 1921, 191.... ROBERT J. KRAUTH Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know of any

(Duration) yrs. mos. ds.

(Signed) H K Gorter M. D. (Coroner.)

4-5, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, April 5, 1921

20-UNDERTAKER H M Rowlson

ADDRESS 230 N Green

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Daniel C Gordon

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52654

CERTIFICATE OF DEATH.

64 D 52654

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2111 E Chase ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel C Gordon

(a) RESIDENCE. NO. 2111 E Chase ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Gordon

6 DATE OF BIRTH (month, day, and year) June 7, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired do

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Daniel Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Gurney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm B. Gordon
(Address) 2034 E Lebanon St

15 Filed APR 5 - 1921 ROBERT L. KRAUSE, Registrar

Dr. Long 1207 E Monumental Pharmacy Store

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1920 to Apr. 3, 1921, that I last saw h.... alive on Apr. 1, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Rt. comp

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Alvin F. Long, M. D.

, 19 (Address) 1207 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	4-6 1921
20 UNDERTAKER Wm Cook	ADDRESS 502 E N. Ave

N. B.—WHITE PAPER, BLACK INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52655

D 52655

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 S. Eastle ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Carrow.

(a) RESIDENCE. No. 325 S. Eastle ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. 11 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Carrow.

6 DATE OF BIRTH (month, day, and year) May. 29th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoemaker.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 88

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware.

PARENTS

10 NAME OF FATHER John Carrow.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Margaret Carrow
(Address) 325 S. Eastle St.

15 Filed APR 5 - 1921 ROBERT J. KRAUSE Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1921, to April 4, 1921, that I last saw h alive on March 31, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(duration) yrs. 6 mos. ds.

CONTRIBUTORY Exhaustion
(Secondary)
(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb N. Pusey, M. D.

, 19 (Address) 1028 Pattersan Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delaware City Del. Cemetery	April 6th 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 408 S. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52656

D 52656 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 17 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claude Ward

(a) RESIDENCE. No. #742 W. Franklin St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant David Easton

(Address) 976 Pa ave

15 Filed APR 5 - 1921 19.... ROBERT J. SLATER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to April 2, 1921, that I last saw him alive on April 2, 1921, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

~~Pulmonary~~ Tuberculosis of Vertebrae - Ca. Pott's Disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. Hurtleni M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 5 19
20 UNDERTAKER David Easton	ADDRESS 976 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of CAUSE OF DEATH in plain terms, so that it may be correctly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Body at city morgue

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52657

CERTIFICATE OF DEATH.

4156D 52657

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 523 W Mulberry ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME A. C. Dunpoop

(Residence in Baltimore: No. 523 W Mulberry St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	W.	Don't Know

6-DATE OF BIRTH, Don't Know (Month) 1 (Day) (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Don't Know

PARENTS.

10-NAME OF FATHER, " "

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- APR 5 - 1921 ROBERT J. KRAUSE

Filed, 191 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(Duration) A few hrs. mos. ds.

CONTRIBUTORY (Secondary) Suicide

(Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D. (Coroner.)

4-2, 1921 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, UNIVERSITY OF MARYLAND. DATE OF BURIAL, , 19

20-UNDERTAKER (Commissioner Health, Per Wm E. WOODALL) ADDRESS APR 5 - 1921

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Morgue

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52658

CERTIFICATE OF DEATH.

D 52658

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital St., 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nettie Colton

(Residence in Baltimore: No. 84 Carlton St St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, March (Month), (Day), 1897 (Year)

7-AGE,	If LESS than 1 day,
24 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): Private family

9-BIRTHPLACE, (State or Country), Kent County

PARENTS.

10-NAME OF FATHER, Harry Colton

11-BIRTHPLACE OF FATHER (State or Country), Kent County

12-MAIDEN NAME OF MOTHER Victoria Sisco

13-BIRTHPLACE OF MOTHER (State or Country), Kent Co,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Colton

(Address) Kent Co Md

15- Filed APR 5 - 1921 ROBERT N. [illegible] Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs, Pericarditis, Following Removal of Tonsils

(Duration) yrs. mos. 1/4 ds.

CONTRIBUTORY (Secondary)

(Duration) n/a yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

Mar 24 1921 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 6 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Kent Co Md

Former or usual residence Kent Co Md

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, , 19

20-UNDERTAKER Commissioner Health.

ADDRESS APR 5 - 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52659 ✓ +92 D 52659

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hospital #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 31 WARD) 24

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ashlock

(a) RESIDENCE. No. US. Public Health Hospital #56 ST. Fort McHenry WARD Md.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 4 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) --

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Elbert T. Rembert Registrar

(Address) US. PHS Hosp. #56 Ft. McHenry Md.

15 Filed APR 5 - 1921 ROBERT E. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1921, to April 3, 1921, that I last saw h. im alive on April 3, 1921, and that death occurred, on the date stated above, at 9 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar(right)

7 days. (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? on board ship.

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Herman E Payne, M. D.

Senior Surgeon (R)

, 19 (Address) US.PHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norge Va

DATE OF BURIAL April 5, 1921

20 UNDERTAKER G. Lanigan & Bro

ADDRESS 127 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52660 HEALTH DEPARTMENT—CITY OF BALTIMORE 91 D 52660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Russell

(a) RESIDENCE. NO. 1524 E. Pratt St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed Robert P. Harrison, Registrar

APR 5 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1921. to April 3, 1921. that I last saw him alive on April 3, 1921. and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(old cerebral thrombosis)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) B Herman, M. D.

4/4/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 1921
20 UNDERTAKER	ADDRESS
Wendell Oppelsdorf	373 Ann

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52661

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp. ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo J. Kell

(a) RESIDENCE. No. 1628 Bank ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Dec 29, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~13~~ 12	3	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria Va.

PARENTS

10 NAME OF FATHER John W Kell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alex. Va.

12 MAIDEN NAME OF MOTHER Adelaide Roland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alex. Va.

14 Informant (Address) John W Kell 1628 Bank St

Filed APR 5 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) april 4 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1 21, 19..., to April 4 21, 19...

that I last saw him alive on April 4 21

and that death occurred, on the date stated above, at 11 P.M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Generalized peritonitis due to ruptured Appendix

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 1.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Schlenker M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Alexandria Va.	April 8 1921
20 UNDERTAKER	ADDRESS
T. A. Frame & Son	703 Franklin

BEFORE SIGNING BE CERTAIN ALL ITEMS ARE ANSWERED. ANY ERRORS SHOULD BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52662

CERTIFICATE OF DEATH.

180

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Forrest Place ST.: 10 WARD)

2-FULL NAME Annie Montgomery

(a) RESIDENCE. No. 1120 Forrest Place ST.: WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary C. O'Brien
(Address) 1120 Forrest Place

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

PR5—1921 Burial Permit No. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to April 4, 1921, that I last saw her alive on April 2, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Artio Sclerosis

(duration) 2 yrs. 6 mos. one ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Newton, M. D.

(Address) 1006 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	April 9 1921
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Nephritis

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 52663

CERTIFICATE OF DEATH.

91 D 52663

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 E. Fort Ave. ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys May Lusby.

(Residence in Baltimore: No. 416 E. Fort Ave. St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White	Single

6-DATE OF BIRTH, July (Month) 13 (Day), 1915 (Year)

7-AGE,	If LESS than 1 day,
5 yrs. 8 mos. 27 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Massachusetts

PARENTS.

10-NAME OF FATHER, Wm. A. Lusby

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Josephine Bloom.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Schwabland

(Address) 416 E. Fort Ave.

15- Filed APR 5 - 1921, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4-1- 1921, to 4-6- 1921, that I saw her alive on 4-5- 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Tuberculosis Lung

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. D. Thompson M. D.

4-5-, 1921 (Address) 423 E. Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	4/7, 1921
20-UNDERTAKER	ADDRESS
J. Fen McCauley	130 E. Fort.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52664

HEALTH DEPARTMENT—CITY OF BALTIMORE

43 D 52664

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 E. Barney ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Miller

(a) RESIDENCE. No. 500 E. Barney ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John I. Miller

6 DATE OF BIRTH (month, day, and year): Oct 20, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bedford Pennsylvania

PARENTS

10 NAME OF FATHER: Samuel Defibaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Belford Pennsylvania

12 MAIDEN NAME OF MOTHER: Lavinia Oyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bedford Pennsylvania

14 Informant: Nellie Hamilton

(Address): 500 E Barney St

15 Filed: Robert P. Harrison, Registrar

APR 5 - 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): apr, 5 1921

17

I HEREBY CERTIFY, That I attended deceased from May, 21, 1916, to April 5, 1921, that I last saw h[illegible] alive on April 2, 1921, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Scirrhus Carcinoma
of Left Breast

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Pulmonary metastasis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) David Franklin M. D.

4/5, 1921 (Address) 122 W See St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bedford Pa.	4/6 1921
20 UNDERTAKER	ADDRESS
J. Fow McCully	130 E. Fort

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52665

CERTIFICATE OF DEATH.

138

D 52665

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Jefferson & 2nd Sts Brooklyn ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Dehn.

(a) RESIDENCE. No. Jefferson & 2nd Sts Brooklyn ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William D Dehn.

6 DATE OF BIRTH (month, day, and year) not known

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
34	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry Slouch.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William Dehn. (Address) Brooklyn.

15 Filed APR 5 - 1921, 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1921, to April 1, 1921, that I last saw her alive on March 29, 1921, and that death occurred, on the date stated above, at 10 45 A m.

The CAUSE OF DEATH* was as follows:

Post Partum Eclampsia

(duration) yrs. mos. 1 hr

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Delivered Mar 26

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emil Novak, M. D.

(Address) 26 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	4-6 1921
20 UNDERTAKER Edward B Hartle	ADDRESS 115 E Preston

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52666 ✓ D 52666

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2661 Harlem Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Smith

(a) RESIDENCE. No. 2661 Harlem Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16 - 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist, Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER George W. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Catherine Casey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Elly Smith (Address) 1621 Hennison St

15 Filed APR 5 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 13 1921, to Mch 22 1921, that I last saw him alive on Mch 22 1921, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease (Mitral)

(duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 4 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? (Over)

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Ordinary methods

(Signed) George C Shannon, M. D.

, 19 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	April 8 1921
20 UNDERTAKER Geo. J. Smith	ADDRESS 1006 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

I have attended this patient for 5 or 6 years. Called as occasion required. He was found dead in bed and I issue this certificate by permission of Coroner Hennessy.

Apr. 5/21 Geo. A. Hamon M.D.

(See affadavit over)

D 52667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D 52667

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ..... St. ..... WARD)

2-FULL NAME Hopkins Hosp Fonzo E. Bedell

(Residence in Baltimore: No. 1411 Poplar Grove St.. yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Single

6-DATE OF BIRTH, Dec 26 (Month) (Day) 1900 (Year)

7-AGE, 20 yrs. 3 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, James W Beall

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER, Edith Watkins

13-BIRTHPLACE OF MOTHER (State or Country), Montgomery Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F E Beall

(Address) 1411 Poplar Grove St

15- Robert P. Harrison,

Filed APR 5 1921, 191.... Registrar.

Burial Permit Ordered

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 3 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns Clothes caught fire from stove

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Kemp Bell M. D. (Coroner.)

4-5, 1921 (Address) 2 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Hill DATE OF BURIAL, April 6, 1921

20-UNDERTAKER A S Marshall ADDRESS 353 Fulton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(William J. Busick)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52668

CERTIFICATE OF DEATH.

+45

D 52668

1-PLACE OF DEATH ~~Lakeville Md.~~

CITY OF BALTIMORE: (No. 2508 Benson St. St.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. W. J. Busick, Sr.

(a) RESIDENCE. NO. Lakeville, ST. Md. WARD Lakeville, Dorchester Co. Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. 9 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11- 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER James Busick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosie Easley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) E. C. Busick 2508 Benson St

15 Filed PR 5 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1921

17 I HEREBY CERTIFY, That I attended deceased from March 29 1921, to April 4 1921;
that I last saw h.. alive on April 4, 1921;
and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Cystoscopic

(Signed) Robert E Finke, M. D.

, 19 (Address) 1418 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Apr 6 1921
20 UNDERTAKER	ADDRESS
A S Marshall	353 Fall Rd

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52669

HEALTH DEPARTMENT--CITY OF BALTIMORE (Piercy) 66

D 52669

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1117 Garrison ave ST.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob M Piercy

(Residence in Baltimore: No. 1117 Garrison ave St.: 79 yrs. 4 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Nov 25th, 1841 (Month) (Day) (Year)

7-AGE: 79 yrs. 4 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Officer
(b) General nature of industry, business, or establishment in which employed (or employer): U.S. Navy

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: John Piercy

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Jane Foster

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H. Gerlach

(Address) 1824 Cordice st

15. Robert P. Harrison,

Filed ....., 191.....

APR 5 - 1921 Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 5 (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1, 1920, to. Oct 5 1921, that I saw h~~im~~ alive on Oct 4, 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... yrs. 3 mos. 5 ds

Contributory (SECONDARY) Hypostatic Pneumonia

(Duration) ..... yrs. 1 mos. 5 ds.

(Signed) J C Mitchell M. D.

Oct 5, 1921 (Address) 32 Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: April 8 1921

20-UNDERTAKER: Johnson & Candles

ADDRESS: 946 Hollins st

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52670

HEALTH DEPARTMENT—CITY OF BALTIMORE

80 ✓ D 52670

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 523 Wyett ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Moudshour

(Residence in Baltimore: No. 523 Wyett St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, Jan (Month) 17 (Day), 1850 (Year)

7-AGE, 71 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Ephrum Moudshour

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Catherine Hollenberry

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Canman

(Address) Galena Md

15- Filed APR 6 - 1921 ROBERT J. [illegible] Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Sudden (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M. Faulon M. D. (Coroner.)

4-5 ..., 1921 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence 523 Wyett St.

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery

DATE OF BURIAL, April 6., 1921

20-UNDERTAKER W M Rowton

ADDRESS 2238 N Howard ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52671 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52671

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 Winter ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Williams

(a) RESIDENCE. NO. 122 Winter ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry Williams

6 DATE OF BIRTH (month, day, and year) May 11 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hannah Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Genevieve Williams

(Address) 122 Winter St

15 Filed APR 6 - 1921 ROBERT J. BRAUTIGAM Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/2/ 1921, to 4/4/ 1921, that I last saw h[illegible] alive on 4/4/ 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous nephritis (duration) yrs. 2 mos. 10 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Microscopic

(Signed) J. Tim Bowley, M. D.

4/5/ 1921 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Apr. 7 1921
20 UNDERTAKER Samuel Hemsley	ADDRESS 578 W Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52672 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52672

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 Division ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Marshall

(a) RESIDENCE. NO. 1732 Division ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) [redacted] Fanny Marshall

6 DATE OF BIRTH (month, day, and year) Jany 21/61

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cattle Raiser

(b) General nature of Industry, business, or establishment in which employed (or employer) — 010

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Fannie Marshall
(Address) 1732 Division St

15 FILED APR 6 - 1921 ROBERT J. KRAUTH Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 27, 1921, to Apr 2, 1921, that I last saw h[illegible] alive on Apr 2, 1921, and that death occurred, on the date stated above, at 6 A — m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank G. Hayne, M. D.

Apr 6, 1921 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Apr 6 1921
20 UNDERTAKER Emmett L. Hensley	ADDRESS 578 N Bdle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52673

80 D 52673

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. #2303 Arunah Ave. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Stephan Whitby

(a) RESIDENCE. No. #2303 Arunah Av. ST., 16 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 70 yrs 3 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Louise Whitby

6 DATE OF BIRTH (month, day, and year) Jany-1-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work State Inspector of 86

(b) General nature of industry, business, or establishment in which employed (or employer) Feed and Fertilizer

(c) Name of employer State of Maryland.

9 BIRTHPLACE (city or town) (State or country) Caroline Co. Maryland.

PARENTS

10 NAME OF FATHER James Madison Whitby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co Maryland.

12 MAIDEN NAME OF MOTHER Catherine Manship

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Caroline Co Maryland.

14 Informant Mrs Mary Louise Whitby (wife)

(Address) 2303 Arunah Ave.

15 Filed APR 6 - 1921 ROBERT I. KRAUTH Registrar

Burial Permit Oler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24 1921, to April 4, 1921, that I last saw h.. alive on April 1, 1921, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Cirrginia Pectoris

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Carey, M. D.

. 19 (Address) 104 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr-6-21 19

20 UNDERTAKER	ADDRESS
STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52674

CERTIFICATE OF DEATH.

D 52674

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE (No. [illegible] St.; 12 Ward) REGISTERED No. C.....

2-FULL NAME Leon Frank

(Residence in Baltimore: No. 501 E. 20 or 21 St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Lyr. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 1, 1911
(Month) (Day) (Year)

7-AGE, 10 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School-Boy
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Louis Frank

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Lena Landsman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Frank

(Address) 501 E. 23rd St.

15- ROBERT B KRAUTH

FILED APR 6 - 1921 1921 Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 5 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic fall of roof.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

April 5, 1921 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs..mos..ds. In the State ..yrs..mos..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rising Sun — DATE OF BURIAL, April 6, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52675

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D 52675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 Bolton St ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Dorsey Davis

(a) RESIDENCE. No. 1301 Bolton St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23rd 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co

PARENTS

10 NAME OF FATHER Allein Bowie Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co

12 MAIDEN NAME OF MOTHER Hester Hilleins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary Davis (Address) 130 Bolton St

15 Filed APR 6 - 1921 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 22 1921, to April 5 1921, that I last saw her alive on April 5 1921, and that death occurred, on the date stated above, at 6. A. m.

The CAUSE OF DEATH* was as follows:

Hepatic Bronchitis which developed into Bronchopneumonia and marked asthenia

Subsequent (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Lusby Tunney, M. D.

. 19 (Address) 812 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 6th 1921
20 UNDERTAKER	ADDRESS
Henry J Jenkins & Son Co	Eichard & Collob

mation should be carefully supplied. Any unknown may be properly classified. Exact statement of OCCUPA CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52676

CERTIFICATE OF DEATH.

+5 D 52676

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Parkwyth St.; 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Schilpp

(a) RESIDENCE. No. 612 Parkwyth St., WARD. 9

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Schilpp

6 DATE OF BIRTH (month, day, and year) July 10 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm Schilpp

(Address) 612 Parkwyth

15 APR 6 - 1921 ROBERT J. BRADY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1921

17 I HEREBY CERTIFY, That I attended deceased from about 3 2m, 19.., to Apr. 5, 1921, that I last saw h.. alive on Apr. 4, 1921, and that death occurred, on the date stated above, at 1:20 a. m.

The CAUSE OF DEATH* was as follows:

Cancer, "Ca" of Epithelioma

(duration) about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) L. J. Preiss, M. D.

, 19 (Address) 634 Gorsuch ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Cemetery York Rd	April 7 1921
20 UNDERTAKER	ADDRESS
W M Rowson	230 N Greene

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Andrew J. Meisel)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52677

CERTIFICATE OF DEATH.

151 D 52677

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 N. Belnord Ave ST.: 7 WARD)

2-FULL NAME Andrew J. Meisel Jr

(a) RESIDENCE. No. 629 N. Belnord Ave St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 2, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Meisel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Muller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Meisel (Address) 629 N. Belnord Ave

15 Filed ..... 19 ..... Registrar

APR 6 - 1921

Burial in Mt Olivet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-2 1921 to 4-5 1921

that I last saw h[illegible] alive on 4-5 1921

and that death occurred, on the date stated above, at 10.0 m.

The CAUSE OF DEATH* was as follows:

Prematurity Birth

(6 hrs)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis 7 Months

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) F. F. Reinecke M. D.

4-5 1921 (Address) 700 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL April 6 1921

20 UNDERTAKER William F. Schaefer — ADDRESS [illegible]

information should be carefully supplied. Any abbreviation should be avoided. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 52678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

116-09 D 52678

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 6 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Celeman Isselkoff

(Residence in Baltimore: No. 1612 E. Baltimore St.; 28 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 49 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Russia

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15-

Filed APR 6 - 1921, 191.. ROBERT B KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 22 1921, to April 6 1921, that I saw him alive on April 6 1921, and that death occurred, on the date stated above, at 2.25 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
followed by pulmonary
edema, post-operative

(Duration) ....yrs. ....mos. 14 ds.

Morbus Brightii
CONTRIBUTORY (Secondary)

(Duration) 2 yrs. X mos. ....ds.

(Signed) Louis Laks M. D.

April 6, 191.. (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 15 ds. In the State 28 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 1612 E. Balto. St.

19-PLACE OF BURIAL OR REMOVAL. Hebrew Benevolent Cem. DATE OF BURIAL, 4/6, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52679

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52679

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerard H. Turner

(a) RESIDENCE. No. Acom Va. ST., WARD. Same Ju.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July ? 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charles Co
(State or country) Md.

PARENTS

10 NAME OF FATHER Zephaniah Turner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Fleet H. Cox
(Address) State's Atty's Office Balto

15 Filed APR 6 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 2, 1921, to Apr. 5, 1921, that I last saw h.im alive on Apr 5, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis-Chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Lyman S. Abbott, M. D.

, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Acom Va	April 8 1921

20 UNDERTAKER Robert Brokeram — Brockett Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52680

D 52680

CERTIFICATE OF DEATH.

REGISTERED NO. 41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tobin

(a) RESIDENCE. NO. 301 W. Biddle St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0 69

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 APR6-1921 ROBERT J. KRAUTH Registrar
Social Form 1 Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1921, to April 4, 1921, that I last saw her alive on April 4, 1921, and that death occurred, on the date stated above, at 7:20 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid Colon

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestional obstruction (duration) yrs. mos. 10 hrs. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) F. A. Holden, M. D.

4/5/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL 4/6 1921

20 UNDERTAKER Mrs N. S. Fink

ADDRESS 1835 W Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--6-9-19—H. P. Co.—1000 Bks.

D 52681

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52681

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 Lake ave ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Frances Barnes

(a) RESIDENCE. NO. 1419 N Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of D. Welton Barnes

6 DATE OF BIRTH (month, day, and year) April 8th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	11	27	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Housewife f86

(b) General nature of industry business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Thomas Evens

11 BIRTHPLACE OF FATHER (city or town) Morgland (State or country)

12 MAIDEN NAME OF MOTHER Leah Collmus

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant J Frank Robinson (Address) 2114 Lake ave

15 Filed APR 6 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1920, to April 4, 1921, that I last saw her alive on Apr 4, 1921, and that death occurred, on the date stated above, at 2 45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pal & Intestinal

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) A B Davis, M. D.

, 19 (Address) 1504 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 7th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52682 HEALTH DEPARTMENT—CITY OF BALTIMORE 42 D 52682

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sarah Kobbert

(Residence in Baltimore: No. 1037 Wilcox St St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Mar 27, 1877 (Month) (Day) (Year) — 1877

7-AGE: 44 yrs. mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: James Herman

11-BIRTHPLACE OF FATHER (State or Country): Balto, Md.

12-MAIDEN NAME OF MOTHER: Not Known,

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William F. Kobbert

(Address) 1037 Wilcox St.

15- Filed APR 6 - 1921 191.....

ROBERT J. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 4, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 3 1921, to April 4 1921, that I saw her alive on April 4 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix

Uremia (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. mos. ds.

(Signed) Nathan J. Blondor M. D.

4-4-21 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Schwan's Cemetery — DATE OF BURIAL, April 8, 1921

20-UNDERTAKER Elmer W. Conklin — ADDRESS 22 N. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52683

D 52683

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Front St. ST.: 5 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Rooney

(a) RESIDENCE. No. 405 N. Front ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thos Rooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Sarah Rooney 17 E Eager St.

15 Filed APR 6-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1921, to April 6, 1921, that I last saw him alive on April 5, 1921, and that death occurred, on the date stated above, at 12-15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Wm Pearce, M. D.

4 6 1921 (Address) 1 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents	April 8 1921
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmount Ave

mation should be carefully supplied. All should be stated EXACTLY. THE FACTS as they may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52684

D 52684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Little Sisters of the Poor, St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Norton

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER Michael Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Mary Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant Sister Florence.
(Address) Preston & Valley Sts.

15 APR 6 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1921

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 .. to ..... 19 ..

that I last saw her alive on April 4 1921,

and that death occurred, on the date stated above, at 11. P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. H. Warner, M. D.

6. 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Apr. 7 1921

20 UNDERTAKER: J. C. Wiedefeld ADDRESS: 914 Greenmount Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52685

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 D 52685

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 805 E Eager ST.: 10 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah McNaney

(Residence in Baltimore: No. 805 E Eager St.: 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH unknown (Month), 1 (Day) (Year)

7 AGE 76 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home

9 BIRTHPLACE (State or country) Ireland

PARENTS

10 NAME OF FATHER Hugh Monaghan

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna McNaney

(Address) 805 E Eager St

15 Robert P. Harrison, 191 REGISTRAR
Burial Permit Clerk.

PR 6 - 1921

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 5, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1921, to April 5 1921, that I saw her alive on April 5, 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Clinical Diagnosis

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY) Arteri-Sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) James M Kenlon M. D.

April 6, 1921 (Address) 720 C Church

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cathedral | DATE OF BURIAL April 1921

20 UNDERTAKER H. C. Kindel | ADDRESS 914 Greenmount

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52686

CERTIFICATE OF DEATH.

D 52686

89

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 West ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Simpson

(Residence in Baltimore: No. 525 West St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Oct. 6, 1914
(Month) (Day) (Year)

7-AGE, 7 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Annapolis Md

PARENTS.

10-NAME OF FATHER, James Simpson

11-BIRTHPLACE OF FATHER (State or Country), Annapolis Md

12-MAIDEN NAME OF MOTHER Susie Evans

13-BIRTHPLACE OF MOTHER (State or Country), Annapolis Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jonas Simpson

(Address) 525 W. West St.

15-

Filed ....., 191.....

Registrar.

APR 6-1921 Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 4 1921, to April 6 1921, that I saw her alive on April 5 1921, and that death occurred, on the date stated above, at 1450 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Infantile Paralysis

(Duration) 6 yrs. ..... mos. ..... ds.

(Signed) J. H. Harrison M. D.

April 6, 1921 (Address) 1303 Dan Ruth

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Ct	April 7, 1921
20-UNDERTAKER	**ADDRESS**
C. L. Brown & Son	108 N. Monroe

Spec.—6-9-19—H. P. Co.—1000 Bks.

Podsiadlo

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52687

CERTIFICATE OF DEATH.

91-090 D 52687

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8. Church Ste Curtis Bay ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kazmiers Podsiadlo.

(a) RESIDENCE. No. 8. Church. Ste ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Stanislaw. Podsiadlo.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Amiela Setczynska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Amiela Podsiadlo
(Address) Curtis Bay

15 Filed ..... 19 .....
Registrar

APR 6-1921 Robert F. [illegible]

Burial Permit [illegible].

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1921, to Apr. 6, 1921, that I last saw him alive on Apr. 4, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William A. Colli, M. D.

Apr. 9 1921 (Address) 816 - Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	April 7 1921
UNDERTAKER	ADDRESS
Wm Hallowell	168 East

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52688

D 52688

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital WARD)

2-FULL NAME Catherine Grabus

(a) RESIDENCE. No. 17 Cole Ave ST. Raspeburg WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5th 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	2	—	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Anthony A. Grabus

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth C. Schneider

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Anthony A. Grabus
(Address) 17 Cole Ave. Raspeburg

15 Filed ..... Robert P. Harrison, Registrar

APR 6-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1921, to April 5, 1921, that I last saw her alive on April 5, 1921, and that death occurred, on the date stated above, at 12.05 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. — mos. ..... ds.

CONTRIBUTORY (Secondary) Syphilitic Aortitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Reaction of Wassermann Symptoms

(Signed) Eugene Brady M. D.

, 19 (Address) 2314 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Joseph's Cemetery

DATE OF BURIAL April 7 1921

20 UNDERTAKER Frederick Lassahn & Sons

ADDRESS Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

147 815 D 52689

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 52689

CERTIFICATE OF DEATH. 8-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Della Moore

(a) RESIDENCE. NO. 3417 First ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21 20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Dorsell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant (Address) Johns Hopkins Hosp. Bonds

15 Filed Robert P. Harrison, Registrar

PR 6-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4- 1921, to April 6 1921, that I last saw her alive on April 6- 1921, and that death occurred, on the date stated above, at 3 15 a m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Orems Cemetery

DATE OF BURIAL 4/7 1921

20 UNDERTAKER William Cook

ADDRESS 502 North

DURATION OF SICKNESS SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIAN'S STATEMENT OF OCCUPATION AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52690 D 52690

CERTIFICATE OF DEATH.

96

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1030 N Fulton Ave ST.; 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Margaret Vaughan

(a) RESIDENCE. No 1030 N Fulton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Vaughan

6 DATE OF BIRTH (month, day, and year): Sept 1845

7 AGE — Years: 75 — Months: 5 — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio Md

12 MAIDEN NAME OF MOTHER: Margaret Warner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Chas B Knapp 1030 N Fulton

15 Filed 19 Robert P Harrison, Registrar

APR 6 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1921

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1921, to April 5, 1921, that I last saw her alive on April 5, 1921, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis and Asthma (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Martin W Shade M. D.

4-6-21 19 (Address) 806 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: April 8 1921

20 UNDERTAKER: H. Deaver & Sons Roth — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

St Louis
806 Fulton Ave

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52691

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Edmonson Ave. ST.; 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Margaret Gibson

(a) RESIDENCE. No. 1310 Edmonson Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos H Gibson

6 DATE OF BIRTH (month, day, and year) Dec 20 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Amelia Neidhoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Charles H. Gibson

(Address) Robert P. Harrison.

15 Filed ..... 19 Burial Permit Clerk. Registrar

APR 6-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1921

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to April 6, 1921, that I last saw h.. alive on March 20, 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William J. Keating, M. D.

, 19 (Address) 200 E Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apr 9 1921
20 UNDERTAKER	ADDRESS
H. Friedman & Sons	Norfolk

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52692

D 52692

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View; 24 WARD)

2-FULL NAME William Volkman

(a) RESIDENCE. No. 615 N. Collington Ave ST., 7th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Volkman

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER William Volkman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Lutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records, New City Hospital.

15 APR 7 - 1921 ROBERT I. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 14, 1921 to April 4, 1921 that I last saw h. alive on April 3, 1921 and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) W. B. Hamman, M. D.

4/4/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Luth. Cem.	April 7 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	1003 S. Wolfe St.

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

WEST

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52693

CERTIFICATE OF DEATH.

3 D 52693

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 Dolphin ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph Augustus West

(a) RESIDENCE. No. 633 Dolphin ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24 - 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER James Anderson West

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Cora Matthews

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Leona Platt
(Address)

15 Filed 4-8-19 21 Dolphin

ROBERT I. BRAUTIGAM
APR 7 - 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5th 1921

17

I HEREBY CERTIFY, That I attended deceased from April 3rd, 19 21, to April 5th, 19 21,

that I last saw h... alive on April 5th, 19 21,

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Interstitial Pneumonitis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? At Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Burnett Tango, M. D.

4-6, 19 21 (Address) 746 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	April 8 1921
20 UNDERTAKER	ADDRESS
David Earhart	916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52694

CERTIFICATE OF DEATH.

151 D 52694

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 909 Walson ST. 3 WARD)

2-FULL NAME Englent Bruce

(a) RESIDENCE. NO. 909 Walson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Sing'l

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 4-21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Paul Bowen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Sadie Bruce

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Sadie Bruce
(Address) 909 Walson

15 Filed APR 7 - 1921 ROBERT I. KRAUTZ Registrar
Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 192 1

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 19 21, to Apr 6, 21,
that I last saw h... alive on Apr 6, 21,
and that death occurred, on the date stated above, at 9 a, m.
The CAUSE OF DEATH* was as follows:

Independopennent
Seven and half month
delivery at birth -
Premature birth (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) D. C. Barnes, M. D.

Apr 6-21 19 (Address) 22 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	April 7 1921
20 UNDERTAKER John W Henderson	ADDRESS 1924 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52695

CERTIFICATE OF DEATH.

50 D 52695

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. Hughes.

(a) RESIDENCE. No. 1326 Hillsdown ST., WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ann Brown.

6 DATE OF BIRTH (month, day, and year) Dec 22 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64		3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police Sgt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

061

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cleland

12 MAIDEN NAME OF MOTHER Ann Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Hughes (Address) 1326 Hillsdown st

15 APR 7 - 1921 ROBERT J. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to April 5, 1921, that I last saw him alive on April 4, 1921, and that death occurred, on the date stated above, at 8 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. McSmith M. D.

4/2/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL April 8 1921

20 UNDERTAKER Harry W. Ehlen — ADDRESS 1944 W. North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52696

CERTIFICATE OF DEATH.

68

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Birt-

(a) RESIDENCE. No. Baltimore Md- ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 45 yrs. 0 mos. 0 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	68	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Co. Antrim (State or country) Ireland-

PARENTS

10 NAME OF FATHER John Birt

11 BIRTHPLACE OF FATHER (city or town) Co. Antrim (State or country) Ireland-

12 MAIDEN NAME OF MOTHER Catherine Read

13 BIRTHPLACE OF MOTHER (city or town) Co. Antrim (State or country) Ireland-

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat Balto Md

15 FILED APR 7 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1890 . 19.. to April 6th . 1921.

that I last saw h er alive on April 6th . 1921.

and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of the Heart abt 5 or 10 Minutes -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Mania abt (duration) 45 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery . M. D.

April 6th. 1921 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 4/8 1921

20 UNDERTAKER William Cook

ADDRESS 502 E Nott

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 52697

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank P. Kelly

(a) RESIDENCE. No. 914 Hollins St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853 Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 APR 7 - 1921 ROBERT I. LEIUTE Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from October 8, 1920, to April 6, 1921, that I last saw h in life on April 5, 1921, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(No cerebral hemorrhage)
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microspecial test.

(Signed) R Ottenman M. D.

4/6/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Apr 8th 1921
20 UNDERTAKER	ADDRESS
John F. Cowan & Son	902 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52698

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Somerset ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa P. Grasser

(a) RESIDENCE. NO. 1023 Somerset ST., 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 6 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Grasser

6 DATE OF BIRTH (month, day, and year) September 30 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Bridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Ocker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. John G. Grasser
(Address) 1023 Somerset St

15 Filed APR 7 - 1921 Recorded

BOARD OF HEALTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 25 19 21, to April 7th 19 21, that I last saw h[illegible] alive on April 6th 19 21, and that death occurred, on the date stated above, at 12 00 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

April 7th 19 21 (Address) 1301 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 9 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52699

80 D 52699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Paul & Preston - St. 5 11 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Crawford Smith

(a) RESIDENCE. No. Pearl Court Apart. St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 5 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Dora Albert Smith

6 DATE OF BIRTH (month, day, and year) Oct. 30 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney at Law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Marshall P. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Law Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant A. Crawford Smith Jr.

(Address) Emerson Hotel.

15 Filed APR 7 - 1921 ROBERT E. KRUTZ Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1921, to April 6, 1921, that I last saw h[e] alive on April 6, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

about 2 yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary) Arterio Sclerosis

about 2 yrs. mos. ds. (duration)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Violent Painful attacks on

(Signed) Chas. O'Donovan M. D.

April 7, 1921 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 8 1921

20 UNDERTAKER ADDRESS

John B. Spence 1325 N. Caroline St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52700

CERTIFICATE OF DEATH.

1 20

D 52700

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1508 W. Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence J Richmond

(Residence in Baltimore: No. 1508 W Lanvale St St.; 58 yrs., ... mos. ... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Male~~ Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, Dec 29, 1862
(Month) (Day) (Year)

7-AGE, 58 yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Robert Mayo

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Satterfield

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Etta Mayo

(Address) 1508 W. Lanvale St

15- Filed APR 7 - 1921, 191.... [illegible]

Burial Permit Issued [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 20 1921, to April 5 1921, that I saw her alive on April 4 1921, and that death occurred, on the date stated above, at 7-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) at least yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. L. McCandlish M. D.

April 7, 1921 (Address) 906 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, April 8, 1921.

20-UNDERTAKER Chas. E. Franck ADDRESS 58 Madison Ave

D 52701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52701

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. on street in front of 1017 N Carlton St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter L. Camper

(Residence in Baltimore: No. 1624 E. Lafayette ave St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-[illegible] Married (Write the word.)

6-DATE OF BIRTH, July 30, 1863 (Month) (Day) (Year)

7-AGE 57 yrs. 8 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 05

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER Addison Camper

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary Meavitt

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary D. Camper

(Address) 1624 E. Lafayette

15-

Filed APR 7 1921, 191.....

[illegible] Registrar

Burial [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 6, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] (Coroner.) M. D.

4 W., 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Michaels — DATE OF BURIAL, April 8 19.21

20-UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52702

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52702

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Boone ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Martin

(a) RESIDENCE. No. 1909 Boone ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Martin

6 DATE OF BIRTH (month, day, and year) 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Oysters

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Martin Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Pauline Martin
(Address) 1909 Boone St

15 Filed APR 7 - 1921 ROBERT A KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1921

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to April 5, 1921, that I last saw h[illegible] alive on April 5, 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm Pearce, M. D.

4-7, 1921 (Address) 1 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 8 1921
20 UNDERTAKER	ADDRESS
E A Windfield Jr	501 E 22

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52703 — 130 — D 52703

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Longwood ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Gregory

(a) RESIDENCE. No. 1407 Longwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 30 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Gregory

6 DATE OF BIRTH (month, day, and year): March 13, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Bernard Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: ---------- Keerns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. B. D. Ryan
(Address): 1407 Longwood Street

15 APR 7 - 1921 ROBERT J. KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): H- 6" 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to April 11, 1921, that I last saw h[illegible] alive on H" 4°, 1921, and that death occurred, on the date stated above, at 3:25 a m.

The CAUSE OF DEATH* was as follows:

Dilatation
Nephritis (Chronic)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Pulmonary oedema

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) M. B. Thurmond, M. D.

, 19 (Address) 1007 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkersburg, W. Va.	4/7 1921
20 UNDERTAKER	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. If UNKNOWN, that it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52704

D 52704

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1425 E Lombard St ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Conway

(Residence in Baltimore: No. 1425 E Lombard St St.; 41 yrs., 8 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July 29 (Month) (Day) 1879 (Year)

7-AGE, 41 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or estsblishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Daniel Sefton

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Brown

(Address) 1425 E Lombard st

15- APR 7 - 1921 ROBERT J. KRAUSE

Filed....., 191.....

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6 (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 3 191.., to April 6 1921, that I saw her alive on April 5 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Heart Failure

complicating Gastritis

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Stomach Poisoning

Fatal (Duration) ...yrs. ...mos. 3 ...ds.

(Signed) Richard H Easterday M. D.

April 6, 1921. (Address) 1514 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, April 7 1921

20-UNDERTAKER, Chas N. Johnson — ADDRESS 446 N. Carolina

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1060 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 52705

D 52705 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 816 N. Dallas ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia Sutton

(a) RESIDENCE. NO. 816 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June 23 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Dallas Md.

PARENTS

10 NAME OF FATHER Edward Sutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Cornelia Twitti

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Amanda Richardson (Address) 816 N. Dallas St.

15 Filed APR 7 - 1921 ROBERT J. BRAGG Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1921, to Apr. 1921, that I last saw h alive on Apr 5 1921, and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

about a wk
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac arrhythmia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Mayfield Boyd M. D.

6/4/192 (Address) [redacted] 525 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Apr 8 '21
20 UNDERTAKER	ADDRESS
Chris. N. Johnson	446 N. Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52706

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hosp. — ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Leo Wolf. —

(a) RESIDENCE. No. 1908 W. Lombard ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married. —

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Selma Wolf

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jos Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Hirsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob Younger

(Address) 1908 W. Lombard St

15 Filed APR 7 - 1921 ROBERT B. EHRLICH, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar. 25th, 1921, to Apr. 5th, 1921, that I last saw him alive on April 5th, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. —

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)' Acute Cardiac Dilat

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Fred J. Blumfield, M. D.

, 19 (Address) Md. Gen. Hosp. —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	4/6/21
20 UNDERTAKER	ADDRESS
Jahrens Co	16 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52707

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

25-11-091 D 52707

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Sexton St. Morrell Park ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Weaver

(a) RESIDENCE. NO. Sexton St., Morrell Park ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Casper Weaver

6 DATE OF BIRTH (month, day, and year) Dec. 5" 1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Mary Lingan

(Address) Sexton St., Morrell Park

15 Filed APR 7 - 1921 ROBERT F KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6" 19 21

17

I HEREBY CERTIFY, That I attended deceased from 3 - 31, 1921, to 4 - 6, 1921, that I last saw her alive on 4 - 6 - , 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W B Hall, M. D.

, 19 (Address) Halethorpe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 7 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bolton St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61-001 D 52708

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View. WARD 4)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Anastas

(a) RESIDENCE. NO. 425 W. Saratoga St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883.

7 AGE. Years	Months	Days	If LESS than 1 day, hrs. or min.
38.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed APR 7 - 1921 16 Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to April 5, 1921, that I last saw him alive on April 5, 1921, and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Epidemic cerebro-spinal meningitis.

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes. What test confirmed diagnosis? Spinal fluid findings

(Signed) Hesseman, M. D.

4/6/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemtry	April 8 1921
20 UNDERTAKER	ADDRESS
Josiah Lyfor	1600 N. North Av

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52709

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

152 D 52709

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 78 Russell St.; Hollins 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME alice Johnson

(Residence in Baltimore: No. 78 Russell St Hollins St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	Colrd	

6-DATE OF BIRTH, ... 4 (Month) ..... 2 (Day), 1921. (Year)

7-AGE,	If LESS than 1 day,
.....yrs. .....mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jas Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Tilghman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Johnson

(Address) 147 Mosher

15- Filed APR 7 - 1921, 191... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 4 (Month) ..... 7 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 2 1921, to April 6 1921, that I saw h er alive on April 6 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Infection of Navel

..... (Duration) .....yrs. .....mos. 2 ...ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... Wm. B. Hall ..... M. D.

4-7-..., 1921 (Address) Halethorp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos. 7 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	April 7., 1921
20-UNDERTAKER	ADDRESS
M. J. Parham	644 W. Lee St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52710

CERTIFICATE OF DEATH.

28

D 52710

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.) 720 N Wolfe ST. 11 WARD)

2-FULL NAME William Johnson

(a) RESIDENCE. NO. 720 N Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Westfall Co

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Johnson

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Emily Murphy

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Emma Johnson
(Address) Edmondson Pike

15 Filed APR 7 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec, 19 21, to April 6, 19 21, that I last saw h alive on April 6 21, and that death occurred, on the date stated above, at 3 Pm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Hanes Bryd, M. D.

April 6, 19 21 (Address) 607 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL April 1921

20 UNDERTAKER Wm Cahoon & Nattans ADDRESS

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- so that it may be properly classified. CAUSE OF DEATH in plain terms, so that TION is very important. See instructions on back of certificates.

D 52711 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52711

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2251 Robert St.: 15 WARD) REGISTERED NO. C.

(If death occurred in hospital or institution give its NAME instead of street and number fill out No. 18.)

2-FULL NAME William Alvin Smith.

(Residence in Baltimore: No. 2916 Eastonaur St.: 5 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August 23, 1859
(Month) (Day) (Year)

7-AGE, 61 yrs. 7 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Decorator

9-BIRTHPLACE, (State or Country), Washington DC

PARENTS.

10-NAME OF FATHER, Edward Smith

11-BIRTHPLACE OF FATHER (State or Country), Washington D

12-MAIDEN NAME OF MOTHER Elizabeth Davis

13-BIRTHPLACE OF MOTHER (State or Country), Washington D

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet L. Smith

(Address) 2916 Clifton ave

15- Robert P. Harrison,
Filed APR 7 1921, 191.....
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (about 5 minutes)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) and Uremia

(Duration) yrs. mos. ds.

(Signed) J. J. Kennedy M. D.
(Coroner.)

April 7 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state- (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	....., 19....
20-UNDERTAKER	ADDRESS
H. Buckler Sons	

52712 PLACE OF DEATH

D 52712

STATE OF MARYLAND
CERTIFICATE OF DEATH

County .....

Village or City Southern Hospital (No. Greenmount Ave, Balto. Md St. 12 Ward) Registration Dist. No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME E. Carvel Lolley 3 days in city

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widower

6 DATE OF BIRTH: Aug (Month) 20 (Day) 1843 (Year)

7 AGE: 77 yrs 7 mos 17 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Judge
(b) General nature of industry business, or establishment in which employed (or employer): Orphans Court

9 BIRTHPLACE (State or country): Harford Co. Md.

PARENTS

10 NAME OF FATHER: James Walter Lolley

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (State or country): not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Majr O. K. Lolley

(Address) Camp Meade Md

15 Filed ..... 191 ..... REGISTRAR

PR 7-1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 6 (Day) 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1920 to April 6, 1921, that I last saw him alive on April 6, 1921, and that death occurred on the date stated above, at 7-10 p.m.

The CAUSE OF DEATH * was as follows:

Myocardial Decompensation

(Duration) 1 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Chas F Green Jr M. D.

April 7, 1921 (Address) Towson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs — mos 3 ds In the State 77 yrs 7 mos 17 ds

Where was disease contracted, if not at place of death?

Former or usual residence Towson Md

19 PLACE OF BURIAL OR REMOVAL: St James P. E. Church — DATE OF BURIAL: April 8, 1921

20 UNDERTAKER: Balto Co Md — ADDRESS: Chas. S. Black 742 W North ave.

OCCUPATION is very important See instructions on back of certificate.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No 1

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52713

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 N. Luzerne Ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia A Robertson

(a) RESIDENCE. NO. 7 N Luzerne Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Robertson

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Schuman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gordon A Robertson

(Address) 7 N. Luzerne Ave

15 Filed APR 8 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1921, to April 5, 1921, that I last saw h[illegible] alive on 11 4, 1921, and that death occurred, on the date stated above, at 3 45 a m.

The CAUSE OF DEATH* was as follows:

Tumor of Brain

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Arthur C Heavy M. D.

4/6, 1921 (Address) 2600 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr. 8 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Flat St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL items must be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.; 25th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Jacobs -

(a) RESIDENCE. No. 1921 N. Castle - Baltimore ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Jacobs.

6 DATE OF BIRTH (month, day, and year) Aug. 7. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	53	7	20	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Records of Mt Hope Retreat (Address) Baltimore Md -

15 Filed APR 7 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1915, 19 21, to Apr 6, 19 21, that I last saw h alive on Apr 6, 19 21, and that death occurred, on the date stated above, at 11. a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) Chr Chronic Lex Dermatitis - Abt (duration) 0 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	April 9 21
20 UNDERTAKER	ADDRESS
H. Lander Sons	1710 Read

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52715 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52715

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Park Heights Ave & Clarks Lane (ST.) 27 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Schlenderberg

(a) RESIDENCE. No. Park Heights Ave & Clarks Lane WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

N. B.—WRITE PLAINLY, with pen and ink. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Schlenderberg

6 DATE OF BIRTH (month, day, and year) Sept 29. 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 15 years

(b) General nature of industry, business, or establishment in which employed (or employer) Meat Packer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Konrad Schlenderberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Rau

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Schlenderberg (Address) Park Heights Ave

15 Filed Robert P. Harrison, Registrar

APR 7 1921 Burial Permit Check.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1 1920 to April 6th 1921, that I last saw him alive on April 6th 1921, and that death occurred, on the date stated above, at 12.35 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? yes Date of May 28th 20

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Cox MD M. D.

4/6/21 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	April 8 1921
20 UNDERTAKER	ADDRESS
H. Sanders Sons	1710 Park

Spec.—8-24-14—M. & T.—2000 Bks.

D 52716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52716

CERTIFICATE OF DEATH.

8-091

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 N. Eutaw ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Rock

(Residence in Baltimore: No. 1030 N. Eutaw St.; ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F. | 4-COLOR OR RACE, W. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 1st (Day), 1920 (Year)

7-AGE, 1 yrs. 3 mos. 7 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Harvey E. Rock

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Sarah Sanford

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harvey E. Rock

(Address) 1030 Eutaw

15-

Filed....., 191.....

Robert P. Harri[illegible]

Registrar.

APR 7 1921 [illegible] Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 22 1921, to April 7 1921, that I saw her alive on April 7 1921, and that death occurred, on the date stated above, at 8 35 AM m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ....yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Whooping-cough

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry H. Weinberger M. D.

4/7/1921 (Address) 724 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ford Lawn | DATE OF BURIAL, Apl 9, 1921

20-UNDERTAKER Wm Curtis | ADDRESS 602 E Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52717

CERTIFICATE OF DEATH.

D 52717

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Graham

(a) RESIDENCE. NO. 208 Vernal Court ST., ... WARD. .....
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Ed. Palmer Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Amanda Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Hospital Records
(Address) M.T.H.

15 Filed APR 7 1921 19 Burt F. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 23, 1921, to April 5, 1921, that I last saw him alive on April 5, 1921, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? X-ray

(Signed) M. P. Grigsby, M. D.

4-5-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 1921

20 UNDERTAKER — ADDRESS

Commissioner Health

APR 7

UNIVERSITY OF MARYLAND

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52718

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lewin Av West of Md. Rd ST.: 8 WARD)

2-FULL NAME Chas. Howard Oler

(a) RESIDENCE. No. Lewin Av. West of Reisterstown Rd ST.: WARD:

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 2nd 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Journeyman

9 BIRTHPLACE (city or town) Balto Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. Oler

11 BIRTHPLACE OF FATHER (city or town) Balto Co.
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Kennedy

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Grace Franklin
(Address) Lewin Av

15 Filed APR 7 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr. 2, 1921, to Apr. 5, 1921, that I last saw him alive on Apr. 5, 1921, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Failing Heart

(duration) yrs. mos. Dec ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Edmunds, M. D.

4/5 1921 (Address) 1206 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Apl 8 1921
20 UNDERTAKER	ADDRESS
Chesnow & Son	Chestnut Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1920 D 52719

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Mill Race Road WARD) 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Hoodless

(a) RESIDENCE. No. 1504 Mill Race Road STREET. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Hoodless

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edmonia Drawdy
(Address)

15 Filed APR 7 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1920. to April 5, 1921.
that I last saw h. alive on April 5, 1921.
and that death occurred, on the date stated above, at 3.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. 7 mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J Davis, M. D.

4-6, 1921 (Address) 1 80 W 33 4/87

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Homeplace	Apl 9 1921

20 UNDERTAKER Ebenezer Lee ADDRESS Chestnut Ave

mation should be carefully answered. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Woodrow Wilson

Woodrow Higgs

D 52720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175-001

D 52720

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 10 Bond Hospital St. (WARD)

2-FULL NAME Woodrow Higgs

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 800 W. 27 St., St.: yrs. 2 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Baby.

6-DATE OF BIRTH, May 10 (Month), (Day), 1918. (Year)

7-AGE, 2 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), MD

PARENTS.

10-NAME OF FATHER, John Higgs

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Myrtle Pettit

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... John Higgs

(Address).....

15- Robert P. Harri[illegible]

Filed ....., 191.....

[illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month), 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia Lt Lung

Child (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D. (Coroner.)

4-7-, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Mary's Hampden	April 9, 1921
20-UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut Av

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52721 ✓ 120 D 52721

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 E Lafayette av ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Jones

(Residence in Baltimore: No. 203 E Lafayette av St.; ...yrs. 6 mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ...Aber... (Month) ...1... (Day) ...1871... (Year)

7-AGE,	If LESS than 1 day,
...51... yrs. ...0... mos. ...5... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....0

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Frank Ruley

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Sarah Campbel

13-BIRTHPLACE OF MOTHER (State or Country), Ens

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oliver Jones

(Address) 203 E Lafayette av

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

APR 7-1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Apr... (Month) ...6..., (Day) ...1921... (Year)

17- I HEREBY CERTIFY, That I attended deceased from ...Mch... 1921, to Apr 6 1921, that I saw her alive on Apr 6 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

.....Nephritis - Chronic.....

..... (Duration) ...yrs. 6 mos. ...ds.

CONTRIBUTORY (Secondary) Anaemia

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Charles F Bloss M. D.

Apr 7, 1921. (Address) 20 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence New York N. Y.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cemetery	Apr 8, 1921
20-UNDERTAKER	ADDRESS
Ed Roy Stiffler	125 E Hatt ave

15.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52722 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

X42 D 52722

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard & Kelly Hospital 1418 Eutaw Place ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah Headorff.

(a) RESIDENCE. NO. 433 S. Queen ST., WARD. York, Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of Mr. Arthur Headorff. (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York, Pennsylvania

PARENTS

10 NAME OF FATHER Mr. Geo. V. Hedeler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster, Pa.

12 MAIDEN NAME OF MOTHER Laura Hunkle.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Arthur Headorff (Address) 433 S. Queen St. York Pa.

15 Filed APR 8 - 1921 ROBERT I. CRAIG Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1921, to April 8, 1921, that I last saw h.. alive on April 8, 1921, and that death occurred, on the date stated above, at 5-35 9 m.

The CAUSE OF DEATH* was as follows:

Epithelioma of cervix.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Extension into pelvic tissues causing anuria. (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 28, 1921.

Was there an autopsy? No

What test confirmed diagnosis? Exam. of tissue from cervix

(Signed) Robert E. Hunter, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Pa — DATE OF BURIAL April 8 1921

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Broadway

N. B.—WRITE LEGIBLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 52723

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

182 D 52723

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 625 N Bond St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Cooper

(Residence in Baltimore: No. 625 N Bond St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laborer Odd

9-BIRTHPLACE, (State or Country), born in Baltimore

PARENTS.

10-NAME OF FATHER, Perry Cooper

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Laura Johnson

13-BIRTHPLACE OF MOTHER (State or Country), born in Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) by the Wife Laura Cooper

(Address) 625 N Bond St

15-

Filed APR 8 1921, 191.....

ROBERT J KRAUTER
Burial Permit Recorder

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by Pistol

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Ross Tomlin (Coroner.) M. D.

4-6, 1921 (Address) N. S. Gold

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, April 8, 1921.

20-UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52724 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 52724

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverna Johnson

(a) RESIDENCE. No. Dolvale School ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address) M.T.H.

15 APR 8-1921 ROBERT I. BAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from December 13, 1920, to April 6, 1921, that I last saw her alive on April 6, 1921, and that death occurred, on the date stated above, at 12.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) L. H. Fahnestock, M. D.

4-6-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 9 1921
20 UNDERTAKER	ADDRESS
Wm. Robert A. Elliott	1725 Ashland Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52725

CERTIFICATE OF DEATH.

43

D 52725

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1847 N. Castle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Klein.

(a) RESIDENCE. No. 1847 N. Castle ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., If of foreign birth? 67 yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Klein.

6 DATE OF BIRTH (month, day, and year) July 2nd 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Born on board of (State or country) German Steamer in mid ocean.

PARENTS

10 NAME OF FATHER Peter Hercke.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Bitz

13 BIRTHPLACE OF MOTHER (city or town) Germany. (State or country)

14 Informant Mrs. Mary Hercke (Address) Glen Ave & Park Heights Ave

15 Filed APR 8 - 1921 ROBERT E. LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from December 6th, 1920, to April 4th, 1921, that I last saw her alive on April 4th, 1921, and that death occurred, on the date stated above, at 4 o'clock P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of both breasts

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible symptoms

(Signed) Wm. Edward Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Apr 8 1921

20 UNDERTAKER J. Herwig & Co

ADDRESS 2008 Allen

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52726

CERTIFICATE OF DEATH.

31 D 52726

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #930 W. Franklin St. ST.: 18 WARD)

2-FULL NAME Eliza Carberry Spicknall.

(a) RESIDENCE. NO. #930 W. Franklin St. ST. 18 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 8 mos. 5 ds. How long in U. S., If of foreign birth? 70 yrs. 8 mos. 5 ds.

AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates. OCCUPA-

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Albert Spicknall

6 DATE OF BIRTH (month, day, and year) Aug-1-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel High

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) not known
(State or country) not known

14 Informant Chas. A. Spicknall (husband)
(Address) 930 W. Franklin St.

15 Filed APR 8 - 1921 ROBERT I. KRAUSE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5th 1921

17 I HEREBY CERTIFY, That I attended deceased from for post mortem only, 19..., that I last saw h.e alive on 5th day of April 1921, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

1. one obscure lung in abdomen
Sup. found to be tuberculor

(duration) 5-0-6 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? don't know

Did an operation preccde death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? only clinical

(Signed) T T Hill, M. D.

, 19 (Address) 1208 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr-8-1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 Whatcoat ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl & Smith

(a) RESIDENCE. NO. 1026 Whetcoat ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Mo. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mamie Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Andrew Smith
(Address) 1026 N. Whatcoat St

15 Filed APR 8 - 1921 19 ROBERT A KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 19 21

17 I HEREBY CERTIFY, That I attended deceased from 4/2, 19 21, to 4/7, 19 21, that I last saw h— alive on 4/6, 19 21, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Byron Butler, M. D.

, 19 (Address) 2139 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Apr-8 1921

20 UNDERTAKER Edward Ruggold ADDRESS 1463 Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52728

CERTIFICATE OF DEATH.

28 D 52728

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 5 WARD)

2-FULL NAME Daniel Plymer

(a) RESIDENCE. No. 307 Colvin st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Plymer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Tuffert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Hospital Records
(Address) M.T.H.

15 Filed APR 8-1921 ROBERT F. KRAUTER Registrar

Burial Permit 0162

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to April 7, 1921, that I last saw him alive on April 6, 1921, and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. J. Rigney, M. D.

4-7-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL April March 1921

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52729

CERTIFICATE OF DEATH.

D 52729

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 Rosedale Terrace ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Linthicum Hall

(a) RESIDENCE. No. 1430 Rosedale Terrace ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P. Hall

6 DATE OF BIRTH (month, day, and year) Oct 26 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	85	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) George Town D.C.
(State or country)

PARENTS

10 NAME OF FATHER Linthicum

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna Magruder

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) D C

14 Informant Miss Mollie Hall
(Address) 430 Rosedale Terrace

15 Filed APR 8 1921 Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1921

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1921, to April 7, 1921, that I last saw he alive on April 6, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis
old age.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY
(Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery Md	Dec 9 1921

20 UNDERTAKER Wm Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52730

CERTIFICATE OF DEATH.

43 D 52730

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 506 S. Patterson Pk Ave St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Weitzel

(Residence in Baltimore: No. 506 S. Patterson Pk. Ave St.; Sft (yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, May (Month) 30 (Day), 1855 (Year)

7-AGE, 65 yrs. 10 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimor Md

PARENTS.

10-NAME OF FATHER, Conrad Keidel

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C. Schumann

(Address) 506 S. Patterson Pk Ave

15-

Filed APR 8-1921 ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1919, to April 6 1921, that I saw her alive on April 5 1921, and that death occurred, on the date stated above, at 8.20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Eugene Zell M. D.

4/7, 1921 (Address) 1898 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel	April 9, 1921
20-UNDERTAKER	ADDRESS
Wm Cook	502 E Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52731

CERTIFICATE OF DEATH.

91 D 52731

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 N Charles St ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia C. Raborg

(a) RESIDENCE. No. 2201 N Charles St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ (or) ~~WIFE~~ of Widow of Christopher H Raborg

6 DATE OF BIRTH (month, day, and year) May 28 1826

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	94	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas H Turnor

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Marriott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant W H S Hanna

(Address) 2122 E. 22

15 Filed APR 8 - 1921 19 ROBERT P. KRAUSE Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 2, 1921, to Apr 7, 1921, that I last saw h~~er~~ alive on Apr 7, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Catarrhal (Bronchial) Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Debility of old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of nr

Was there an autopsy? nr

What test confirmed diagnosis? Phys. Ex

(Signed) Robert W. Mifflin M. D.

19 (Address) 1016 Mad. Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 11 1921
20 UNDERTAKER	ADDRESS
Henry W Jenkins & Son Co	Edmondson Ave & Collok St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52732

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52732

CERTIFICATE OF DEATH.

55-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson B. Lee

(a) RESIDENCE. No. 1236 Argyle Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Dan Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed APR 8-1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1921, to April 5, 1921

that I last saw him alive on April 5, 1921

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Lethargic encephalitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) B Herman M. D.

4/6/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Cem. Govanstown	Apr 8 1921
20 UNDERTAKER Samuel A Hemsley	ADDRESS [illegible]

N. B.—WRITE PLAINLY. WITH UNFADING INK—THE BLANKS should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52733

CERTIFICATE OF DEATH.

79 D 52733

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2338 Barclay ST.: 12 WARD)

2-FULL NAME Martha E Morris

(a) RESIDENCE. No. 2338 Barclay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Allen Morris

6 DATE OF BIRTH (month, day, and year) Jan 6-1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	3	1	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Balsler Brauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Christina Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Jas. A Eckle
(Address) 2338 Barclay St

15 Filed APR 8—1921 ROBERT B KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1 1914, to April 7th 1921, that I last saw h.. alive on April 6th 1921, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
(duration) about 3 yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W A Finch M. D.

4/7 1921 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: April 9 1921

20 UNDERTAKER: Geo. M. Finh & Son, — ADDRESS: 811 N Wolfe

Funeral Directors & Embalmers.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Brickman

D 52734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52734

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.; 5 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Brickman

(a) RESIDENCE. No. 240 N. Front St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 hr ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) 4/1/21

7 AGE	Years	Months	Days	If LESS than 1 day, 1 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Eli Brickman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Silberman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Eli Brickman

(Address) 112 N. Front St

15 Filed APR 8 1921 ERNEST J. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/1 1921, to 4/7 1921, that I last saw h[illegible] alive on 4/7 1921, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Version & Breech Extraction

(duration) yrs. mos. 1 hr ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/1/21

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Lauren D. Fudge, M. D.

1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	April 8 1921
20 UNDERTAKER Sol Levin	ADDRESS 112 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each question must be answered or the word "unknown" or the proper abbreviation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Hughes

CERTIFICATE OF DEATH.

119 D 52735
REGISTERED NO.

D 52735
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Myrtle ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Hughes

(a) RESIDENCE. No. 1416 Myrtle av ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 fifty mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Dec 5-72

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. Neal

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Francis Adams

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mabel Hughes
(Address) 1416 Myrtle Ave

15 Filed APR 8-1921 ROBERT P. KRAUSE Registrar Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5 19 21

17 I HEREBY CERTIFY, That I attended deceased from 3/18, 1921, to 4/5, 1921, that I last saw h[illegible] alive on 4/5, 1921, and that death occurred, on the date stated above, at 7 1/4 a.m.

The CAUSE OF DEATH* was as follows:

Ac Nephritis
Uremia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 2139 Druid Hill av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grd Auburn	Apr 8 1921
20 UNDERTAKER Geo W Holland	ADDRESS 1631 Druid Hill av

N. B.—WRITE PLAINLY, WITH CARE AND WITHOUT ABBREVIATIONS. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103 D 52736

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2038 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Coleman

(Residence in Baltimore: No. 2038 McCulloh St.; 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1833 (Year)

7-AGE, 88 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... No

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Judith Glasco

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. S. Coleman

(Address) 2038 McCulloh

15- APR 8-1921 Filed....., 191.... ROBERT J. TRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 15 1921, to April 7 1921, that I saw her alive on April 7, 1921, and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Old Age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Montague M. D.

4-7....., 1921 (Address) 2038 McCulloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Upton Perry Cemetery Alabama

DATE OF BURIAL, Apr. 8, 1921

20-UNDERTAKER Sam'l H. Case & Son

ADDRESS 1400 Maker

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 52737

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Tena Roettger.

(a) RESIDENCE. NO. 1915 E. Chase St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Roettger

6 DATE OF BIRTH (month, day, and year) Nov - 1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
48	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER John W. Lamp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lizzie Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Roettger

(Address) 1915 E. Chase st

15 Filed APR 8 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT AND ANY ERASURE OR MISSTATEMENT OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1921, to April 5, 1921, that I last saw her alive on April 5th, 1921, and that death occurred, on the date stated above, at 12.10 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) 10 min. yrs. mos.

CONTRIBUTORY (Secondary) Uterine Fibroid.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 21, 1921.

Was there an autopsy? No.

What test confirmed diagnosis? Signs and Symptoms; Gyneco

(Signed) F. C. Manno. M. D.

April 6, 1921 (Address) St. Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bast Cemtery	April 8th 1921
20 UNDERTAKER	**ADDRESS**
Geo Lenhardt & Son	647 W. Lafayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52738

CERTIFICATE OF DEATH.

28 D 52738

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Cecelia (Bradley)

(a) RESIDENCE. No. St. Mary's Orphan ST. Catonsville

(Usual place of abode) 4 yrs. (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. Roland Park mos. ... ds. How long in U. S., if foreign born? ... yrs. Md mos. ... ds.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Religious

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	22			

8 OCCUPATION OF DECEASED 065

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Boston

PARENTS

10 NAME OF FATHER Thos. Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Edith Henson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Boston

14 Informant Mrs. E. Bradley

(Address) Boston Mass

15 Filed ... 19 ... Registrar

APR 8 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1921, to Apr 6, 1921, that I last saw h alive on Apr 6, 1921, and that death occurred, on the date stated above, at 4:10 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis pulmonary

(duration) yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Oedema of glottis (Tbc)

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. McCrum M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	April 9 1921

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1827 W Fayette St

D 52739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168-001 D 52739

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Monastery Farm House ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas F. Barry

(Residence in Baltimore: No. Monastery Farm Frederick Rd St.; yrs.. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... March ..... (Month), 1 ..... (Day), ... (Year)

7-AGE, about 65 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer)..... Farm

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. J. J. O'Connor

(Address) St. Joseph Monastery

15- APR 8 - 1921 ROBERT I. KRAUSE

14th ..... 191.... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March ..... (Month), 4 ..... (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas, Accident, by Gas

Above Going (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Fenton M. D.
(Coroner.)

April 6, 1921 (Address) 704 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Unknown

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	4/8/21

20-UNDERTAKER ADDRESS

George A. Farley Fulton & Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 52740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52740

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lussie Josephson

(Residence in Baltimore: No. 1411 E Pratt St St.; 16 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH. Unknown ....., 1868
(Month) (Day) (Year)

7-AGE 53 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Louis

(Address) 1411 E Balto St

15- Filed APR 8 - 1921, 191.. ROBERT E LEAUTEE Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-29 1921, to 4-8 1921, that I saw h[illegible] alive on 4-8-1921 191, and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Chronic

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ventral hernia

(Duration) 2 yrs. mos. ds.

(Signed) Louis Jacks M. D.

April 8, 1921 (Address) The Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 10 ds. In the State 16 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1411 E Pratt St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 4-[illegible], 1921

20-UNDERTAKER Jack Louis

ADDRESS 1411 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52741

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52741

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1684 Columbia ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Stumpf

(a) RESIDENCE. NO. 684 Columbia Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Andrew Stumpf

6 DATE OF BIRTH (month, day, and year) Feb 3 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49.	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carrollton Md.

PARENTS

10 NAME OF FATHER Frank A Eckenrode

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Amanda Hoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Andrew Stumpf
(Address) 684 Columbia Ave

15 Filed APR 8 - 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1921

I HEREBY CERTIFY, That I attended deceased from March 30 1921 to April 7 1921

that I last saw him alive on April 7 1921

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

CONTRIBUTORY (Secondary) Uterine fibroids (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes April 6. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Schweinitz, M. D.

19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	April 11 1921
20 UNDERTAKER	ADDRESS
W M Coulson	230 E Green

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52742

CERTIFICATE OF DEATH.

41 D 52742

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2321 N Northern ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John G. McCoy

(Residence in Baltimore: No. 2321 N Northern ave St.; 20 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April 17, 1859.
(Month) (Day) (Year)

7-AGE, 61 yrs. 11 mns. 19 ds. If LESS than 1 day, ...hrs. or ....mln.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mfg Agent
(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Richard B McCoy

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Nancy Galbreath

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie McCoy

(Address) 2321 N Northern ave

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

APR 8 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to April 6 1921, that I saw h[im] alive on April 6 1921, and that death occurred, on the date stated above, at 8.30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestine (Large)

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Intestine (Large)

(Duration) 1 yrs. 4 mos. ds.

(Signed) G W Billups M. D.

April 8, 1921. (Address) 2224 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Fawn Grove Pa.	April 9., 1921.
20-UNDERTAKER H M Rowton	ADDRESS 230 N Green

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 52743 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52743

CERTIFICATE OF DEATH.

50

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2037 E 32nd St. WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. Ferdinand Schilling

(Residence in Baltimore: No. 2037 E 32nd Street St. 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 16 (Day), 1852 (Year)

7-AGE, 69 yrs. 11 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) clothing shop

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, don't know

11-BIRTHPLACE OF FATHER (State or Country), don't know

12-MAIDEN NAME OF MOTHER don't know

13-BIRTHPLACE OF MOTHER (State or Country), don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Hunker

(Address) 2037 E. 32nd St

15-

Filed APR 8 - 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit [redacted]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Apr 8 1921, that I saw h[illegible] alive on Apr 7 1921, and that death occurred, on the date stated above, at 1:15 a. m.

The CAUSE OF DEATH* was as follows:

Diabetis Millitus

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic coma

(Duration) yrs. mos. 3 ds.

(Signed) Wm. A. Todd M. D.

4/8, 1921. (Address) 735 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemtty

DATE OF BURIAL, April 9, 1921

20-UNDERTAKER Josiah Leffler

ADDRESS 1600 W North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52744

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52744

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Zunecke

(a) RESIDENCE. NO. 302 S Appleton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) DEC 16. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER John H. Homen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant [illegible] (Address) [illegible]

15 Filed Robert P. Harrison, Registrar

APR 8 - 1921

Burial Permit [redacted]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15 1921. to Apr. 6 1921.

that I last saw h[illegible] alive on Apr. 6 1921.

and that death occurred, on the date stated above, at 11.45a m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of [illegible] 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. [illegible] M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	4/9 1921
20 UNDERTAKER Robert Brockenbrough Hollins	Cashman scs

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52745

CERTIFICATE OF DEATH.

20 D 52745

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward W. Giles

(a) RESIDENCE. No. 2943 Belmont Ave. ST.. WARD Walbrook, Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Edward W. Giles

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER Kurd Giles -

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Maron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Hospital Records
(Address)

15 Filed Robert P. Harrison, Registrar

APR 8-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1921, to April 8, 1921, that I last saw him alive on April 8, 1921, and that death occurred, on the date stated above, at 10.57 a. m.

The CAUSE OF DEATH* was as follows:

Suppurating Phlebitis - Lt. leg -
Septicaemia (Staphylococcus aureus)
(Primary infection Lt. foot.)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Tobacco -
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home -

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? Blood culture -

(Signed) J. H. Hammersbaum, M. D.

Apr 8 1921 (Address) U. M. Hos.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Apr 11 192
20 UNDERTAKER	ADDRESS
Wm. F. Tickell	1605 North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52746

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52746

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3404 Park Heights St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Benjamin Strawbridge Jr

(a) RESIDENCE. No. 3404 Park Heights St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Herbert N Strawbridge

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna

12 MAIDEN NAME OF MOTHER Jeannette Campbell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Herbert N Strawbridge
(Address) 3404 Park Heights

15 Filed APR 8-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1921, to April 8, 1921.

that I last saw h im alive on April 7, 1921.

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Prematurity (7 mo. child)

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Maurice E. Shamer, M. D.

4/8, 1921 (Address) 3300 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	April 1921
20 UNDERTAKER	ADDRESS
H Thurnes Sons	Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52747

CERTIFICATE OF DEATH.

151 D 52747

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 N Stricker ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Alexander Stewart

(Residence in Baltimore: No. 1819 N Spring St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, 4 (Month) 3 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Alexander Stewart

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lettie Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Stewart

(Address) 1819 N. Spring Ave

15- Recd ..... 191.....

Apr 9 1921 Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 3, 1921, to Apr 8, 1921, that I saw h.... alive on Apr 8 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows: Premature birth, Omphalocele, Umbilical hernia

(Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R Gardner Shumate M. D.

Apr 8, 1921. (Address) 1534 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion — DATE OF BURIAL, Apr 9, 1921.

20-UNDERTAKER Mrs R A Abbott — ADDRESS 1725 Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52748 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52748

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 4 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Smith

(a) RESIDENCE. No. Westminster, Md. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or estsblishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Smith

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Grace Gibson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Louis Smith
(Address) R.D. Westminster, Md.

15 Filed APR 9-1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/7, 19 21, to 4/9, 19 21, that I last saw h[illegible] alive on 4/9, 19 21, and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Otitis Media
(Non-Tuberculous)
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Septic Meningitis
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Westminster, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lewis O. Riggs, M. D.

4/9, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmony Grove Cem.	4/11-1921
20 UNDERTAKER C. M. Walty	ADDRESS Winfield

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52749

CERTIFICATE OF DEATH.

8-041

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 946 N. Washington ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Virginia Cunningham

(a) RESIDENCE. No. 946 N. Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER James B. Cunningham

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Edna Valiant

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant James J. Cunningham (Address) 946 N. Washington st

15 Filed ..... 19 Robert P. Harrison, Registrar

APR 9 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1921, to April 9, 1921, that I last saw her alive on April 8, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Albert Singer M. D.

4/9/ 1921 (Address) 1613 E. Fourth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL April 11 1921

20 UNDERTAKER Firkler & Firkler — ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52750

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 S. Durham ST.; 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul H. Hodges

(a) RESIDENCE. NO. 128 S. Durham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jesse H. Hodges

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Wilhelmina Paul

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Jesse H. Hodges
(Address) 128 S. Durham St

15 Filed APR 9 - 1921 Robert P. Harris Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from ~~April~~ March 21 1921, to April 8, 1921, that I last saw him alive on April 7, 1921, and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Dystochia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Alfred A. Bendick, M. D.

, 19 (Address) 88 Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	April 9 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52751 92 D 52751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 723 Belgian Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Charles Brown Jr.

(Residence in Baltimore: No. 723 Belgian Ave St.; ..... yrs., 11 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, May (Month) 7th (Day), 1920 (Year)

7-AGE, ... yrs. 11 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Child

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Robt C. Brown

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Agnes Forestell

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt C. Brown Jr.

(Address) 723 Belgian Ave

15-

Filed ..... 1921 Robert P. Harrison, Registrar.

APR 9 - 1921 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 6 1921, to April 8th 1921, that I saw h me alive on April 7th 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

..... Lobar Pneumonia .....

..... (Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) None

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Wm P Cannon M. D.

April 8, 1921. (Address) 1 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cath. Cem — DATE OF BURIAL, 4/9, 1921

20-UNDERTAKER Geo. J. Rush — ADDRESS 1735 Hanford Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52752 ×28 D 52752

D 52752

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST. 24 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph S Winterling

(a) RESIDENCE. No. US. Public Health Hosp. #56 ST. Fort McHenry Baltimore Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 237 Colgate mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Joseph S Winterling

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar Kranbrook (Address) US?PHS Hosp. #56 Ft McHenry Md.

Filed ..... 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk APR 9 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to April 8, 1921, that I last saw him alive on April 8, 1921, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary (active)

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Thomas B. Payne M. D.

, 19 (Address) US. PHS Hosp. #56 Ft McHenry Md. Senior Surgeon (R

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	April 12 1921
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52753

CERTIFICATE OF DEATH.

D 52753

170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 E. Barney ST. 23 WARD)

2-FULL NAME William Steinbock

(a) RESIDENCE. NO. 34 E Barney ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Steinbock

6 DATE OF BIRTH (month, day, and year) Jan 18-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. pd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Steinbock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Mary Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant (Address) Mrs Steinbock 34 E Barney St.

15 Filed ..... 19.....

Registrar

APR 9 - 1921 Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1921

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to Apr 8, 1921, that I last saw h.. alive on April, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Thrombosis.

(duration) ..... yrs. ..... mos. 5 days

CONTRIBUTORY (Secondary) Chronic Bright's Disease (duration) 1 yrs. 0 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Shipley Evans, M. D.

4/9, 1921 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk	4/11 1921
20 UNDERTAKER	ADDRESS
J. Frew McCully	1305 Frank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 N. Mount ST.; 15 WARD)

REGISTERED NO. C 1579

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nora Phillips

(Residence in Baltimore: No. 1501 N. Mount St.; 46 yrs., 11 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Married

6-DATE OF BIRTH, April 10, (Month) (Day) 1875 (Year)

7-AGE,	If LESS than 1 day,
46 yrs. 11 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Ezekiel Brown

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Josephine Smith

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph E. Phillips

(Address) 1501 N. Mount St.

15- APR 9-1921 191.... Robert P. Harris, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7, (Month) (Day) 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to April 6, 1921, that I saw h[illegible] alive on April 6, 1921, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. 1 mos. ds.

(Signed) E. Lee Hayne M. D.

April 9, 1921 (Address) 1413 Druid Pk.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Md Auburn Cem. DATE OF BURIAL, April 10, 1921.

20-UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52755

CERTIFICATE OF DEATH.

REGISTERED NO. 3892

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 S. Bond. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Nerwinski

(a) RESIDENCE. NO. 400 S. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24—1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alexander Nerwinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Gratowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Alex Nerwinski 400 S Bond

15 Filed APR 9 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1921, to April 7, 1921, that I last saw her alive on ....., 19....., and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

....(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) none

....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. G. Fordeus, M. D.

, 19 (Address) 918 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	4/9 1921
20 UNDERTAKER	ADDRESS
Wm Galkowski & Co	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D 52756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52756

CERTIFICATE OF DEATH.

8D

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 146 Loudon Ave St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian L Blaeuer

(a) RESIDENCE. No. 146 Loudon Ave St. 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 4. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) For himself

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Catonsville Md

PARENTS

10 NAME OF FATHER Wilhelm Blaeuer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helena Preininger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wilhelmine Blaeuer

(Address) 146 Loudon

Filed APR 9 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to April 6, 1921, that I last saw him alive on April 6, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

10 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Sclerosis

Cerebral Softening

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W W Jones M. D.

19 (Address) 467 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem Cemetery Catonsville Md	Apr. 9 1921

20 UNDERTAKER Geo. L Schwab & Bro ADDRESS 2101 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52757

D 52757

CERTIFICATE OF DEATH.

X 150

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. North Broadway ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May Reid Wallace

(a) RESIDENCE. NO. Newberry S.C. ST. WARD. Newberry S. C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 2- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Newberry
(State or country) S. Carolina

PARENTS

10 NAME OF FATHER W B Wallace

11 BIRTHPLACE OF FATHER (city or town) Newberry.
(State or country) S Carolina

12 MAIDEN NAME OF MOTHER May Reid

13 BIRTHPLACE OF MOTHER (city or town) Newberry
(State or country) S Carolina

14 Informant W B Wallace
(Address) Newberry S Carolina

15 Filed APR 9 1921, 19.....

Robert F. Duffy
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1921, to April 8, 1921, that I last saw her alive on April 8, 1921, and that death occurred, on the date stated above, at 10:25 p.m.

The CAUSE OF DEATH* was as follows:

Spina Bifida

(duration) Congenital mos. ds.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 8, 1921

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. D. Noble, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newberry Carolina	Apl 9 21

20 UNDERTAKER H E Hughes

ADDRESS 424 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52758

CERTIFICATE OF DEATH.

120 D 52758

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 Hubbard Alley 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Lawson

(a) RESIDENCE. NO. 603 Hubbard Alley ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widow

5a If married, widowed, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of Thomas Lawson deceased

6 DATE OF BIRTH (month, day, and year) July 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Eliza Haskins (daughter) deceased
(Address) 603 Hubbard Alley

15 Filed ....., 19.....

Robert P. Harrison, Registrar

APR 8 - 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1921, to April 6 1921, that I last saw h.er alive on 3/6/21 1921, and that death occurred, on the date stated above, at 2/0/21 12 t. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam. + Lab. work

(Signed) R. F. Young, M. D.

, 19 (Address) 1416 Jefferson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	April 10 1921

20 UNDERTAKER ADDRESS

R C Gross 1405 McElderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1469 34 D 52759 — CERTIFICATE OF DEATH. — × 77 ✓ D 52759

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse H. Sheets

(a) RESIDENCE. NO. 44 Liberty St. Westminster Md WARD. Westminster Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2.3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Sheets

6 DATE OF BIRTH (month, day, and year) Dec 25 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	3	13	

8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work Railroader 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. W. Sheets

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Rachael Krantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address) J. H. Hosp.

15 Filed ....., 19..... Registrar

APR 9 - 1921 Robert C. Harrison, Clerk. Charles Steer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 - 1921

17 I HEREBY CERTIFY, That I attended deceased from March 17 -, 1921, to April 9 -, 1921, that I last saw h... alive on April 9 -, 1921, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial infiltration.
Purulent fibrillation. DUE
Pericarditis. chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of scrotum & penis
Shock (duration) 3 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 4/6/21

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) J. T. Bailey, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	Apr 9/21
20 UNDERTAKER	ADDRESS
Wm Cook	501 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for urethritis.
No history of gonorrhoeal
infection.
External urethrotomy.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52760 D 52760

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1370 Calhoun ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Frances Chase

(a) RESIDENCE. NO. 1370 Calhoun ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wesley Chase

6 DATE OF BIRTH (month, day, and year) [illegible] 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer Daymake

9 BIRTHPLACE (city or town) (State or country) Winchester

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Robert A Chase (Address) 1370 Calhoun St

15 Filed APR 10 1921 19 ROBERT I KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to April 6, 1921, that I last saw h.. alive on April 5, 1921, and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) E. Wallace Frey, M. D.

4/6, 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery Friedrich md	April 10- 1921
20 UNDERTAKER	ADDRESS
John H Toadvine	1624 Hillen

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D52781 HEALTH DEPARTMENT—CITY OF BALTIMORE D52781

114

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2725 Dillon St. W 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonina Czarski

(a) RESIDENCE. No. 2725 Dillon St. W 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Jan 17-1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jan Kaczmarski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Maryana Biednarska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Czarski (Address) 2725 Dielon St

15 Filed APR 10 1921 16 ROBERT A. CARTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1921, to Apr. 8, 1921, that I last saw h[er] alive on Apr. 8, 1921, and that death occurred, on the date stated above, at 10 5 a.m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(Ruptured gall-bladder.)

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted ✓ If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. B. Athey, M. D.

4/9, 1921 (Address) 2504 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	April 11 1921
20 UNDERTAKER	ADDRESS
Stephen L Fialkowski	[illegible]

D 52762 MARY Mummaugh D 52762
D 52760 D 52760

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 167 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST.: 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Mummaugh

(Residence in Baltimore: No. Woodmondale Md St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ..., ..., 1 .....
(Month) (Day) (Year)

7-AGE, ...57....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

9-BIRTHPLACE, (State or Country), ~~Md~~ Md Known

PARENTS.

10-NAME OF FATHER, Md Known

11-BIRTHPLACE OF FATHER (State or Country), Md Known

12-MAIDEN NAME OF MOTHER Md Known

13-BIRTHPLACE OF MOTHER (State or Country), Md Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....F. Reese.....

(Address)....Westminster Md.

15- APR 10 1921 ROBERT J. BRUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 8, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paresis 2 years
Arteriosclerosis
Contributory (Secondary) Cardiac
(Duration) yrs. mos. ds.

(Signed) H. Reese M. D.
(Coroner.)
Aug 8, 1921. (Address) Westminster Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death 1 day yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Westminster Md

DATE OF BURIAL, April 10., 1921.

20-UNDERTAKER W M Routson

ADDRESS 230 N Greene

EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 52763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 52763

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 N. Wolfe ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry M Thompson

(Residence in Baltimore: No. 1808 N. Wolfe St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Apr 21, 1910
(Month) (Day) (Year)

7-AGE, ... yrs. 11 mos. 19 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry M Thompson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Virginia Stone

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Thompson

(Address) 1808 N. Wolfe St

15-

Filed APR 10 1921, 191.... ROBERT E KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 24 1921, to Apr 9 1921, that I saw him alive on Apr 8 1921, and that death occurred, on the date stated above, at 7.40 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jacob Frisch M. D.

Apr 4, 1921 (Address) 1833 E Mass Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cath Cem. DATE OF BURIAL, 4/11/21, 191...

20-UNDERTAKER Geo. J. Ruth ADDRESS 1735 Hanford Ave

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate. ... should be stated EXACTLY. PHYSICIANS should state ... may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52764

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mirian Smith

(a) RESIDENCE. No. 804 S. Charles St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balti. Md.

PARENTS

10 NAME OF FATHER Daniel T. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Eckhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) John Hopkins Hospital Records.

15 Filed APR 10 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17

I HEREBY CERTIFY, That I attended deceased from April 6 1921, to April 9 1921, that I last saw her alive on April 9 1921, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Retropharyngeal Abscess

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

4-9, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Apr 10 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52765

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52765

CERTIFICATE OF DEATH.

REGISTERED No. C 25 150

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 122 Elm Ave, Curtis Bay. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Tarnowski.

(Residence in Baltimore: No. 122 Elm Ave. Curtis Bay. St., ~~yrs.~~ ~~mos.~~ 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, March 21st. 1921., 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
~~yrs.~~ ~~mos.~~ 19 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Antone Tarnowski.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Alexandra Karwowska.

13-BIRTHPLACE OF MOTHER (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antone Tarnowski. (father)

(Address) 122 Elm Ave. Curtis Bay.

15- APR 10 1921 ROBERT F KRAUTER
Filed....., 191.....
Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 9th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
Mitral Insufficiency.
congenital.
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

April 9, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross AA Co	April 10 1921
20-UNDERTAKER	ADDRESS
John McWeber	1803 Bank St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52766

CERTIFICATE OF DEATH.

91 D 52766

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Glyndon Ave ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence J. Stallings

(Residence in Baltimore: No. 1216 Glyndon Ave St.; Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, March 8th. 1920
(Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 1 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country),
Balto. Md.

PARENTS.

10-NAME OF FATHER, Benjamin R. Stallings

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Loella Musgrove

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Benjamin R. Stallings
(Informant).....
(Address) 1216 Glyndon Ave.

15- APR 10 1921
Filed....., 191.... ROBERT J. [illegible]
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 9, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to April 9, 1921, that I saw h[illegible] alive on April 8 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 40 ds.

CONTRIBUTORY (Secondary) Respiratory failure

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) G. G. Rusk, M. D.

Apr. 10, 1921. (Address) 1301 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loyden Park Cem	4/11/21, 191...
20-UNDERTAKER	ADDRESS
Jos Deguiar & Son	1100 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 52767

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 402 E 22nd St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie M Stansbury

(a) RESIDENCE. NO. 402 E 22nd St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward H Stansbury

6 DATE OF BIRTH (month, day, and year): Dec 10/1850

7 AGE: Years 70 Months 3 Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Nicholas H Myerman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rebecca Bixby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Edward H Stansbury (Address) 402 E 22nd St

15 FILED APR 10 1921 ROBERT J BRAUTEN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 28, 1921, to April 9, 1921, that I last saw her alive on April 5, 1921, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Mucenic Poisoning

(duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) John S Green Jr. M. D.

, 19 (Address) Towson, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem DATE OF BURIAL: April 11 1921

20 UNDERTAKER: W B Leak ADDRESS: 502 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52768 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52768

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2911 W. North Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles. G. Flaharty

(a) RESIDENCE. No. 2911 W. North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced (write the word)~~
Male	White	Married

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of Lillie. M. Flaharty

6 DATE OF BIRTH (month, day, and year) July 6 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	7	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work B. O. Baggage Master
(b) General nature of Industry, business, or establishment in which employed (or employer) 013
(c) Name of employer B. O. R R

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER Thomas Flaharty
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Dont Know
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Lillie. M. Flaharty
(Address) 2911 W. North Ave

15 Filed APR 10 1921 ROBERT B KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from April 6th, 1921, to April 8th, 1921, that I last saw him alive on April 7th, 1921, and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows:

Chronic Paranelymatous Syphilitis

unknown (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? microscopical analysis

(Signed) Irwin Charles Hertz, M. D.

, 1921 (Address) 1116 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Apr 11 1921
20 UNDERTAKER	ADDRESS
Jos Sourdens Son	2178 Pa.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52769

D 52769

CERTIFICATE OF DEATH.

REGISTERED NO. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5000 Palmer ave St. Wilkinson WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Stein

(Residence in Baltimore: No. 5000 Palmer ave St.; 9 yrs., mos. ds.)

Formerly from 623 Ensor Street

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, ... (Month) Unknown (Day) ....., 1882 (Year)

7-AGE, 39 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Emmuel Stutman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Minnie Louis

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aaron Stein

(Address) 5000 Palmer ave

15-

Filed APR 10 1921, 191.....

ROBERT J. KRAUTER (Clerk)

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 9 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1921, to April 9 1921, that I saw her alive on Apr 9 1921, and that death occurred, on the date stated above, at 9:15 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Bernard M. Beugarth M. D.

Apr 9, 1921. (Address) 3447 Pk Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 9 yrs. mos. ds.

Where was disease contracted, if not at place of death? Do not know

Former or usual residence 623 Ensor St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 4-10, 1921

20-UNDERTAKER, Jack Levis

ADDRESS 1411 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-119 D 52770

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 David Hill Ave ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Valentine Fitzgerald

(a) RESIDENCE. No. 1118 David Hill Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. 8 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Daisy C Fitzgerald

6 DATE OF BIRTH (month, day, and year) Feb 14, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10 NAME OF FATHER Joseph M Fitzgerald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Mary Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant C C Fitzgerald

(Address) 2038 David Hill Ave

15 Filed APR 10 1921 ROBERT A BAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1921

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to April 7, 1921, that I last saw him alive on April 7, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) H. S. M Caul, M. D

4/9. 1921 (Address) 2005 David Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	April 10 1921

20 UNDERTAKER John H Graham ADDRESS 142 N Main

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 52771

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Graves

(a) RESIDENCE. No. 2829 Remington Ave. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Wildon Graves

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Alice Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Address) Hospital Records, New City Hospital.

15 [illegible] APR 10 1921 [illegible] Registrar

Postal Inquiry Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to April 8, 1921, that I last saw her alive on April 7, 1921, and that death occurred, on the date stated above, at 7:00 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri.
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis.
(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) Patterman. M. D.

4/8/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr. 10 1921

20 UNDERTAKER Samuel Hensley Biddle ADDRESS 578

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 52772

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 643 Vine St ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Ewell

(a) RESIDENCE. NO. 643 Vine St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George EWELL

6 DATE OF BIRTH (month, day and year) Mch 23-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Ind

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Augustus Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Rosella Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Geo E Ewell

(Address) 643 Vine St

ROBERT F RESUTEK

15 Filed APR 10 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apl 7th 1921

17

I HEREBY CERTIFY, That I attended deceased from Mch 10 1921 to apl 7th 1921

that I last saw h[illegible] alive on apl 6th 1921

and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Gustav Kohlman M. D

19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Apr 10 1921
20 UNDERTAKER	ADDRESS
Samuel L Kennedy	378 N Bridle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52773 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52773

CERTIFICATE OF DEATH. X 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 4 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Walker

(a) RESIDENCE. No. Mitchellsville Rd St., Ward. Mitchellsville Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Emma Walker

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Daniel Carter

(Address) 916 Penna ave

15 Filed APR 10 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 7, 1921, to April 7, 1921, that I last saw him alive on April 7, 1921, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(Duration) 2 days mos. 36 hrs. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 7, 1921.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cyrus F. Hoover, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Lawn	April 10 1921
20 UNDERTAKER	ADDRESS 916 Pa ave
Daniel Easter	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52774

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-091 D 52774

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4205 Belview Ave ST.; 28 WARD)

2-FULL NAME Sarah Ann Gray

(a) RESIDENCE. No. 4205 Belview Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander P. Gray

6 DATE OF BIRTH (month, day, and year) July 5. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George N. Isaac

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nancy A Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nellie J. Gray

(Address) 4205 Belview Ave

15 Filed APR 10 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 31 1921, to April 8 1921, that I last saw her alive on April 6 1921, and that death occurred, on the date stated above, at 10.55 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? The physical signs

(Signed) Clarke Gray, M. D.

, 1921 (Address) 1111 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	April 11 1921

20 UNDERTAKER John O. Mitchell ADDRESS 1201 N. Payson St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52775

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 Club Road, Roland Park ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Wilson

(a) RESIDENCE. NO. Darlington, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 22, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Darlington, Md

PARENTS

10 NAME OF FATHER David E. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) D C Wharton Smith 2nd Sewer Dept

15 APR 10 1921 ROBERT I. FEATHER Registrar

Burial Permit Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1921, to April 10, 1921, that I last saw her alive on April 10, 1921, and that death occurred, on the date stated above, at 5 10 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumococcus Septicaemia (Group I)

(duration) 0 yrs. 0 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) D C Wharton Smith 2nd, M. D.

, 19 (Address) Sewer Dept. Baltimore, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Darlington Cem	April 12 1921
20 UNDERTAKER J. Perkins & Son	ADDRESS Cathedral & Preston

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 52776

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. 608 Nicoll Ave ST.: Govans WARD)

2-FULL NAME Rachel Grace Vansant

(a) RESIDENCE. No 608 Nicoll Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm M Vansant

6 DATE OF BIRTH (month, day, and year) July 12 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Stephen Moser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah McElwee

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs W Vansant (Address) 608 Nicoll Ave

15 Filed APR 10 1921 ROBERT J KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1920, to April 6, 1921, that I last saw h[er] alive on April 6, 1921, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis;

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Geo A Hoehing

(Signed) M. D.

, 19 (Address) 5830 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presbyterian	April 19[2]1
20 UNDERTAKER	ADDRESS
H Frederick Jones	Govans Md

CAUSE OF DEATH is very important. See instructions on back of certificates. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52777

CERTIFICATE OF DEATH.

1, 20 D 52777

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3905 Forest Park ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth B. Amoss

(Residence in Baltimore: No. 3905 Forest Park ave St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept (Month) 28 (Day), 1847 (Year)

7-AGE, 73 yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Thomas S. Clark

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Isabella Clark

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Palmo Donnell

(Address) 3905 Forest Park av

15- Filed APR 10 1921, 191..... ROBERT E. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 2 1921, to April 8th 1921, that I saw h.. alive on April 7th 1921, and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

..... (Duration) — yrs. — mos. 6 ds.

(Signed) Hobart F. Gilleman M. D.

April 9th, 1921 (Address) 1227 W Lafayette ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Apr. 11, 1921

20-UNDERTAKER Geo J Smith — ADDRESS 1000 W. Fayette st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6 Dennis Mc Cool

D 52778

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 184 D 52778

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dennis McCool

(Residence in Baltimore: No. Unknown St.; yrs., 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Don't know

6-DATE OF BIRTH, ... Don't Know, (Month) (Day) Don't (Year)

7-AGE,	If LESS than 1 day,
65 about yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland Don't Know

PARENTS.

10-NAME OF FATHER, Dennis McCool

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Louis Howard

(Address) 901 Hollins St

15-

Filed APR 10 1921, 191.... ROBERT I. EDAUTH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 4 (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy ~~or inquiry~~,) thereon and from the evidence obtained by said..... (Inquest, autopsy ~~or inquiry~~,) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) supposed to have been caused by some person at this time ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

4-9, 1921. (Address) 11 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters Cemetery	Apl 11, 1921
20-UNDERTAKER	ADDRESS
John J. Howard & Son	901 Hollins St.

GE should be stated EXACTLY. PHYSICIANS should state every item of information should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52779

CERTIFICATE OF DEATH.

175-005 D 52779

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Pierson

(Residence in Baltimore: No. 1321 Scott St.; yrs. 57 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Aug (Month) 1863 (Day) (Year)

7-AGE, 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Pierson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Lee

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ella Pierson

(Address) 1321 Scott St.

15- APR 10 1921 ROBERT A. LEAUTH Burial Permit Registrar

Filed ..... 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 9 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull caused by falling from wagon

(Duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Accident

(Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D. (Coroner.)

4-10, 1921. (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	April 12, 1921

20-UNDERTAKER	ADDRESS
John Howard Doe	901 Hollins St

ALL. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

52780 HEALTH DEPARTMENT—CITY OF BALTIMORE 52780

CERTIFICATE OF DEATH.

29.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ling Joe

(a) RESIDENCE. No. # 230 Park Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 (Single) Married, Widowed, or Divorced (write the word)
Male	Chinese	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant Owner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Ling Chu Hong

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Wong Shee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Ling How

(Address) 702 Market St. Wilmington Del.

15 Filed APR 11 1921 ROBERT J. BAUER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from January 24, 1921, to April 9, 1921, that I last saw him alive on April 9, 1921, and that death occurred, on the date stated above, at 2 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Cardio Renal Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Meyer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Conn	Apr 11 1921
20 UNDERTAKER John O. Mitchell	ADDRESS 1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

58781 B 32781

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 58781 32781

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Old Frederick Road & Athol Ave ST., 28 WARD)

2-FULL NAME Charles H. Renner,

(a) RESIDENCE. No. Old Frederick Road & Athol Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or WIFE) Mary E. Renner

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Hanover, Germany.

PARENTS

10 NAME OF FATHER Henry Renner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover, Germany

12 MAIDEN NAME OF MOTHER Elizabeth Kurr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Eliz. Sherwood,

(Address) 2213 Whitelock Ave.

15 Filed APR 11 1921 ROBERT F. BAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from March 16, 19 21, to April 9, 19 21, that I last saw h.. alive on April 8, 19 21, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. W. Young, M. D.

4-9 19 21 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Apl. 14 1921
20 UNDERTAKER	ADDRESS
J. W. Offutt, Jr.	320 E. Lanvale St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52782

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 52782

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 525 S. Chapl (St.) V (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bluszewicz.

(a) RESIDENCE. No. 525 S. Chapl St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Pawel Bluszewicz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General natore of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Adam Odachowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Maryanna Odachowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Pawel Bluszewicz
(Address) 525 S. Chapl

15 Filed APR 11 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5 1921, to April 8 1921,
that I last saw h.r alive on April 8 1921,
and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Acute (duration) ....yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur J. Gibson, M. D.
(Address) 801 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	4/11 1921
20 UNDERTAKER Wm Grabowski	ADDRESS 1618 E.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52783

CERTIFICATE OF DEATH.

47

D 52783

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 N. Luzerne Ave. St. 8 WARD)

2-FULL NAME Felix John Gittner.

(a) RESIDENCE. No. 1331 N. Luzerne ave St. 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16 1905

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
15	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John B. Gittner

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Martha Zicklestein

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Martha Schleuning.
(Address) 1331 N Luzerne Ave.

15 Filed APR 11 1921 ROBERT J. BRAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1921, to April 9, 1921, that I last saw him alive on April 7, 1921, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Endocarditis - Acute dilatation of the Heart.

(Duration) — yrs. 1 mos. 30 ds.

CONTRIBUTORY (Secondary) Rheumatism and Endocarditis (Duration) 8 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ~~at~~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. G. Cappeze, M. D.

19 (Address) 2303 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	April 12th 1921
20 UNDERTAKER Lilly & Sons	ADDRESS 403 S. Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52784

CERTIFICATE OF DEATH.

91 D 52784

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 S. Chester ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Albert Kneavel

(a) RESIDENCE. NO. 230 S. Chester ST., 2 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2nd 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Bernard F. Kneavel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Viola Kenwicki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Bernard F. Kneavel.
(Address) 230 S. Chester St.

15 Filed APR 11 1921 ROBERT I. CRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 9, 1921, to —, 19—, that I last saw h.. alive on Apr. 9, 1921, and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Ries, M. D.

Apr. 9, 1921 (Address) 24 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	April 11 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeller	403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52785

CERTIFICATE OF DEATH.

1921 D 52785

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2538 W. Pratt ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Hickman

(a) RESIDENCE. NO. 2538 W. Pratt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Hickman

6 DATE OF BIRTH (month, day, and year) Jan 26. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Household Duties

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob Romoser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Frederick J. Hickman (Address) 2538 W. Pratt St.

15 Filed APR 11 1921 ROBERT S. BRUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th 1921

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to , 19 , that I last saw her alive on April 8, 1921, and that death occurred, on the date stated above, at 1.30 P. M.

The CAUSE OF DEATH* was as follows:

Endocarditis (Enlargement)
Chr Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C. Hatch, M. D.

4/9/1921 (Address) 2151 Baltimore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 11th 1921
20 UNDERTAKER	ADDRESS
The Mrs. John H. Deitel & Son	801 W. Fayette

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should be stated EXACTLY. Every item of information should be supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Ruta

HEALTH DEPARTMENT—CITY OF BALTIMORE

42

D 52786

D 52786

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 Hanover Av ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ruta

(Residence in Baltimore: No. 1824 Hanover Av St.; 31 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 25 (Day), 1880 (Year)

7-AGE, 31 yrs. ..... mos. 15 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Cento Garcia

11-BIRTHPLACE OF FATHER (State or Country), Spain

12-MAIDEN NAME OF MOTHER Mary Lore

13-BIRTHPLACE OF MOTHER (State or Country), Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred. Ruta

(Address) 1824 Hanover Av

15- APR 11 1921 BOARD OF HEALTH

Filed ....., 191.. BURIAL PERMIT Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 20 1921, to April 9 1921, that I saw h.. alive on April 5 1921, and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

.....

Carcinoma of Uterus

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dropsy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. H. White M. D.

April 10, 1921 (Address) 200 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oakdale

DATE OF BURIAL, April 12, 191.

20-UNDERTAKER Frank Boeckeler

ADDRESS 1600 Madison Av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52787

CERTIFICATE OF DEATH.

28 D 52787

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N Chapel ST.: 7 WARD)

2-FULL NAME Marie Pazderka PAZDERKA

(a) RESIDENCE. NO. 509 N. Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sewing

(b) General nature of industry, business, or establishment in which employed (or employer): 069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Vincent Pazderka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Rosa Brudra

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Rose Pazderka
(Address) 509 N Chapel

15 Filed APR 11 1921 ROBERT A. LEAUTEY Registrar

Burial Permit Issued

Done Vincent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 9, 1921, that I last saw her alive on April 6, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Cardiac Dilation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

4/10/21 (Signed) Edw J Gsell, M. D.
(Address) 501 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 12 1921
20 UNDERTAKER: Earl Enoch & Son	ADDRESS: 1906 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52788 HEALTH DEPARTMENT—CITY OF BALTIMORE 92 D 52788

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 Cambridge ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Helen Rodgers

(Residence in Baltimore: No. 2322 Cambridge St.; 7 yrs., 4 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, April (Month) 3" (Day), 1914 (Year)

7-AGE, 7 yrs. — 3 mos. 3 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): paid

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Henry C. Rodgers

11-BIRTHPLACE OF FATHER (State or Country), Wash. DC

12-MAIDEN NAME OF MOTHER, Margaret O'Connell

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry C. Rodgers

(Address) 2431 Fair Ave.

15. APR 11 1921 ROBERT F. BRAUTIGAM
Filed....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 8 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 6 1921, to April 8 1921, that I saw h[illegible] alive on April 8 1921, and that death occurred, on the date stated above, at 7 30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fraser Hampson M. D.

4/8, 1921 (Address) 2431 Fair Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Patricks Cem | DATE OF BURIAL, Apr. 11", 1921

20-UNDERTAKER Jos. B Cook | ADDRESS 1003 W. Balto St.

SPACES MUST BE FILLED IN PHYSICIANS should state DISEASE OR CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52789 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

138 D 52789

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1808 E Federal ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia E Smith

(a) RESIDENCE. NO. 1808 E Federal ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm E Smith

6 DATE OF BIRTH (month, day, and year) Dec 26/1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butts Md.

PARENTS

10 NAME OF FATHER Edward Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary S. Hook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm E Smith
(Address) 808 E Federal

15 Filed APR 11 1921 1921 ROBERT J. BRAUTE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan-1, 1921, to April 10, 1921, that I last saw her alive on April 9. 1921, and that death occurred, on the date stated above, at 4. A m.

The CAUSE OF DEATH* was as follows:

Chron. Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post Puerperal Eclampsia

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H E Hess, M. D.

4.10.1921 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 13 1921

20 UNDERTAKER Wm Cook ADDRESS 502 E Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52790

CERTIFICATE OF DEATH.

79 D 52790

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 West Mosher St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Riddlemoser

(a) RESIDENCE. No. 130 West Mosher ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George W. Riddlemoser

6 DATE OF BIRTH (month, day, and year) Jan 20 - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Shanaraugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Campshire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Joseph Riddlemoser
(Address) 130 West Mosher

15 Filed APR 11 1921 ROBERT A. [illegible] Registrar

Burial Permit Dist.

Dr. Hoag 729 Columbia Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1921, to April 9, 1921, that I last saw her alive on April 9, 1921, and that death occurred, on the date stated above, at 1.55 P.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Dudley S. Hoag, M. D.

4/10. 19 (Address) 729 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	4/12 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E. N. Ave

...ctions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52791

D 52791

CERTIFICATE OF DEATH.

6 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2324 E. Fairmount ave ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Kelso

(a) RESIDENCE. No. 2324 E. Fairmount ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Benj. Kelso

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emma Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Emma Kelso
(Address) 2324 E. Fairmount ave.

15 Filed APR 11 1921 ROBERT J. BRAUER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 4 1921, to April 8, 1921, that I last saw him alive on April 6, 1921, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Arthur L. Kaye M.D.

4/8, 1921 (Address) 1600 E. Pratt St. City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Apr. 11 1921

20 UNDERTAKER ADDRESS

Wm. C. Black 927 N. Broadway

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probable due to
Syphilis

Spec.—8-24-14—M. & T.—2000 Bks. EDITH SMITH

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52792

CERTIFICATE OF DEATH.

15 D 52792

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 N Mont ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Smith

(Residence in Baltimore: No. 1630 N Mont Ave St.; ..... yrs., ... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 8, 1921 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 1 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... home
(b) General nature of industry, business, or establishment in which employed (or employer)..... ——

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Ferdinan Smith

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Florence Briggs

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ferdinan Smith

(Address) 1630 N Mont Ave

15- APR 11 1921 ROBERT F KRAUTER

Filed....., 191.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1921, to April 10 1921, that I saw h— alive on April 9 1921, and that death occurred, on the date stated above, at 2a. m.

The CAUSE OF DEATH* was as follows:

..... Pneumonia Lobar .....

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas Herbert M. D.

April 11, 1921 (Address) Maple Ave & Belvedere

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, April 11, 1921

20-UNDERTAKER Fickler & Fickler — ADDRESS 1739 Eager

CAUSES OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52793

D 52793

154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 Powell ave (Parkhurst) ST.; 26 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Susanna Mullyan

(Residence in Baltimore: No. 37 Powell ave St.: 90 yrs., 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb 24, 1831 (Month) (Day) (Year)

7-AGE. 90 yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Benjamin German

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER. Katherine Krebs

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J German

(Address) 37 Powell ave

15- ROBERT J KRUTH

Filed APRIL 1921, 191. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 7 1921, to April 8th 1921, that I saw h[illegible] alive on April 7 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Old Age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Gustave A Fut M. D.

4/8, 1921 (Address) Arcadia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	April 12 1921
20-UNDERTAKER	ADDRESS
Henry Lutz	1007 N. Bond st

IMPORTANT.—PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52794

CERTIFICATE OF DEATH.

X-44 D 52794

REGISTERED No.

1-PLACE OF DEATH US. Public Health Hospital #56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 24th WARD)

2-FULL NAME Peter Harris

(a) RESIDENCE. No. US. Public Health Hospital #56 ST., Fort McHenry Baltimore Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs. or min.
54 yrs.	-	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbush Registrar
(Address) US. PHS Hosp. #56 Ft McHenry Md.

15 Filed APR 11 1921 ROBERT F. ARMISTEAD Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1920, to April 7, 1921, that I last saw h.im alive on April 7, 1921, and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma right ear.

(duration) yrs. 18 mos. --- ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Clinic report & Lab Repor

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)

4/7, 1921 (Address) US. PHS Hosp. #56 Ft McHenry Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	April 11 1921
20 UNDERTAKER S. Pearson & Bro	ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52795 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52795

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH US Public Health Hosp. #56

REGISTERED NO.....

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST.: 35 WARD) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yates Haislip

(a) RESIDENCE. NO. 430 Pinkney Place US. Public Health Hosp; #56 ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) ---

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35 yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country) unknown

12 MAIDEN NAME OF MOTHER unk own

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country) unknown

14 Informant Edgar T. Rowbuck Registrar
(Address) US. PHS Hosp. #56 Ft McHenry Md.

15 Filed ....., 19 .....
Registrar

APR 11 1921 Burial Permit Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to Arpil 10, 1921, that I last saw him alive on Arpil 10, 1921, and that death occurred, on the date stated above, at 2:55 p.m.

The CAUSE OF DEATH* was as follows:

Acute miliary Tuberculosis,

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ----

Was there an autopsy? No

What test confirmed diagnosis? Exam. Clinic report.

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)

, 19 (Address) US. PHS Hosp. #56 Ftlicheury Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Loudon Pk	4/12 19
20 UNDERTAKER	ADDRESS
R. S. Marshall	3539 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

Holley.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52796

CERTIFICATE OF DEATH.

104 D 52796

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 Lehr's Lane St.: 20 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Holley

(a) RESIDENCE. No. 29 Lehr's Lane St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles H Holley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elsie E. Thomas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant Charles Holley (Address) 29 Lehrs Lane

15 Filed APR 11 1921 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24 1921, to April 10th, 1921, that I last saw h[illegible] alive on April 10th, 1921, and that death occurred, on the date stated above, at 4-25 P. m.

The CAUSE OF DEATH* was as follows: Intestinal Intoxication

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Drunkenness

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bunnell Forge, M. D.

(Address) 746 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 12 1921
20 UNDERTAKER	**ADDRESS**
Sam'l H. Chase & Son	1400 Mad. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Sparks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52797 ✓

D 52797

10-154 52797

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hillen Road near Register 21 WARD) Govans

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Sparks

(Residence in Baltimore: No. ~~#25 years~~ Hillen Rd near Register St.; yrs. 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH, June (Month) 7 (Day), 1846 (Year)

7-AGE, 74 yrs. 10 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Elijah Brown

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Elizabeth A. Anderson

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Burns Sons

(Address) Towson md

15- ROBERT F KRAUTER

Filed APR 11 1921 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 10 (Day), 1921. (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1st 1921, to Apr 10 1921, that I saw him alive on Apr 9th 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Inflamation of eye with La Grippe

(Duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) yrs. mos. ds.

(Signed) E. H. Duncan M. D.

Apr. 10, 1921. (Address) 506 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Prospect Hill Cem. DATE OF BURIAL, April 13 1921.

20-UNDERTAKER John Burns Sons ADDRESS Towson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52798 HEALTH DEPARTMENT—CITY OF BALTIMORE

136 ✓ D 52798

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 524 S. Sharp St. ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie Henly.

(Residence in Baltimore: No. 524 S. Sharp St. St.; 22 yrs., 9 mos. 15 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Married

6-DATE OF BIRTH, June 23rd. 1898. (Month) (Day) 1 (Year)

7-AGE, 22 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George W. Pumphrey.

11-BIRTHPLACE OF FATHER (State or Country), A. A. Co. Md.

12-MAIDEN NAME OF MOTHER Alice Hale.

13-BIRTHPLACE OF MOTHER (State or Country), Arkansas.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Pumphrey (mother)

(Address) 7 E. Fort Ave.

15- APR 11 1921 ROBERT B KRAUTER

Filed ....., 191... Deputy Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7th. 1921. (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
Rubture of the Uterus during labor.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Otto Reinhardt M. D. (Coroner.)

April 9, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Leakin Park	April 11, 1921
20-UNDERTAKER	ADDRESS
Geo. Lehnert Bro.	2101 Fredk. Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52799

D 52799

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 5522 York Road ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine H. Wheeler.

(a) RESIDENCE. NO. 5522 York Road ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry W. Wheeler.

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Not Known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Minnie Spellgar (Address) 5522 York Road

15 Filed APRIL 1921, 19 ROBERT I. KRAUTLE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to Apr 9, 1921, that I last saw her alive on Apr 5, 1921, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Paralysis superinduced by Arteriosclerosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. M. Duncan, M. D.

, 19 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Cem Waverly	April 11 1921
20 UNDERTAKER	ADDRESS
E. A. Windsfeld Jr.	501 E 25th St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry. and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52800

D 52800

CERTIFICATE OF DEATH.

89

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 E. Fort ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Fuld

(a) RESIDENCE. (Usual place of abode) Residence 1608 N. Port St. 32 Altona Ave (Buried from) ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Raymond Fuld

6 DATE OF BIRTH (month, day, and year) Dec 14th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lilie Fuld.

(Address) 32 Altona Ave

15 Filed APR 11 1921 ROBERT P. [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to April 9, 1921, that I last saw h[illegible] alive on April 9, 1921, and that death occurred, on the date stated above, at 3. A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis
Gastro-Enteritis

(duration) ....yrs. ....mos. 29 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Murray, M. D.

4-9 1921 (Address) 510 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	April 11 1921
20 UNDERTAKER	ADDRESS
Leo D. Cook	Fort Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52801 HEALTH DEPARTMENT—CITY OF BALTIMORE R 52801

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 Lewis ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Gateway

(a) RESIDENCE. NO. 713 Lewis ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18 yrs	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Horace Gateway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella C Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Ella C Wright Gateway 713 Lewis St

15 Filed APR 11 1921 ROBERT E KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 1921, to Apl 9 1921, that I last saw h-e alive on Apr 8 1921, and that death occurred, on the date stated above, at 4 35 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Dot emia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Edward Fiske, M. D.

4-9 1921 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetary	April 12 1921
20 UNDERTAKER	ADDRESS
Chas. C. Bailey	1421 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52802

CERTIFICATE OF DEATH.

91-061

D 52802

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4006 Groveland Ave St.; 28 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary E Mathison

(Residence in Baltimore: No. 4006 Groveland ave St.; 81 yrs., 9 mos. 4 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 4 (Day), 1839 (Year).

7-AGE, 81 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Samuel Robinson

11-BIRTHPLACE OF FATHER (State or Country), Rhode Island

12-MAIDEN NAME OF MOTHER Smallwood

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Kyle

(Address) 4006 Groveland ave

15- APR 11 1921 ROBERT I KRAUTH

Filed....., 191..... (Day) Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 8 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from March 30, 1921, to April 8 1921, that I saw her alive on April 8 1921, and that death occurred, on the date stated above, at 11.25a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) Cerebral meningitis (Septic)

(Duration) ....yrs. ....mos. 1 ds.

(Signed) C B Connor M. D.

April, 1921. (Address) 5016 Park Heights ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	4 11, 1921
20-UNDERTAKER J J Moran	ADDRESS 3000 E Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52803

CERTIFICATE OF DEATH.

D 52803

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1351 Woodyear ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Smith

(a) RESIDENCE. NO. 1351 Woodyear ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. 6 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Oct 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butts Maryland

PARENTS

10 NAME OF FATHER Nauth Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Berrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Carrington (Address) 1351 Woodyear St

15 Filed APR 11 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8/21 19

17 I HEREBY CERTIFY, That I attended deceased from 3-26-, 1921, to 4-8-, 1921, that I last saw him alive on 4-8-, 1921, and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) Two weeks 5 ds.

*CONTRIBUTORY (Secondary) age 1yr 6 ms

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Baltimore md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W R Boykin, M. D.

19 (Address) 1380 Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn APR 1	1921 19

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52804

CERTIFICATE OF DEATH.

91 ✓ D 52804

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Washington St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Rybicki

(Residence in Baltimore: No. 602 S. Washington St.; ...yrs., ...mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) child

6-DATE OF BIRTH, September 2, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....—
(b) General nature of industry, business, or establishment in which employed (or employer).....—

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Stephen Rybicki

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Sophia Labedzinska

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Rybicki

(Address) 602 S. Washington St

15-APR 11 1921 CONSTANCE BEAUTEN

Filed....., 191... ...Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 11, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 8 1921, to April 11 1921, that I saw him alive on April 10 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchial Catarrh

(Duration) ...yrs. ...mos. 7 ds.

(Signed) John H. Feldberger M. D.

April 11, 1921. (Address) 1709 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	April 12, 1921
20-UNDERTAKER	**ADDRESS**
John McWeber	1803 Bank St

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Kuppier

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52805

CERTIFICATE OF DEATH.

D 52805

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 Andre ST.: 24 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Kuppier

(a) RESIDENCE. No. 1440 Andre. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Kuppier

6 DATE OF BIRTH (month, day, and year) Feb. 3. 1860

7 AGE	Years	Months	Days	if LESS than 1 day, hrs. or min.
	61	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Dry Dock

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Kuppier
(Address) 1440 Andre

15 Filed APR 11 1921 ROBERT F. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5 1920, to Apr. 9 1921, that I last saw him alive on Apr 8 1921, and that death occurred, on the date stated above, at 11.20 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Wm. J. Deaboy, M. D.

4/10, 1921 (Address) 638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Arco	Apr. 11 1921
20 UNDERTAKER	ADDRESS
Margaret T. Flynn	1472 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52806

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2205 Homewood Ave ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Hebner

(a) RESIDENCE. No. 2205 Homewood Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rosetta B. Hebner

6 DATE OF BIRTH (month, day, and year) Dec 31, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Retired 19 yrs,

(b) General nature of Industry, business, or establishment in which employed (or employer) Boiler Works &

(c) Name of employer James P. Coad. Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Hebner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Sarei[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth H. Wells

(Address) 22 Ex Homewood Ave

15 Date APR 11 1921 ROBERT P. LAZURE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 21 2, 1921, to Apr. 10 2, 1921, that I last saw h[illegible] alive on Apr. 9 2, 1921, and that death occurred, on the date stated above, at 2 40 P. m.

The CAUSE OF DEATH* was as follows:

Mitrae Incompetence

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman L. Grening, M. D.

April 11, 1921 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	April 12 1921
20 UNDERTAKER	ADDRESS
A. Sander Sons	1310 Block St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52807

CERTIFICATE OF DEATH.

D 52807

1-PLACE OF DEATH South East Corner

CITY OF BALTIMORE: (No. Washington Boulevard and Ninth St.: 25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August John Frederick Hoffman

(a) RESIDENCE. No. Washington Boulevard 9th St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Olga Hoffman

6 DATE OF BIRTH (month, day, and year) Oct 18th 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Lithographic Co

9 BIRTHPLACE (city or town) (State or country) Charlestown Baltimore Md

PARENTS

10 NAME OF FATHER George G. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Volata Co Md

12 MAIDEN NAME OF MOTHER Anna Elizabeth Mehring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City Md

14 Informant Mrs Olga Hoffman

(Address) Washington Boulevard & 9th St

15 Filed Nov 1 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1920, to April 9, 1921, that I last saw h. alive on April 8, 1921, and that death occurred, on the date stated above, at 3.50 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) same

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Gardner Steffan, M. D.

April 11 1921 (Address) Monument & Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	April 12th 1921

20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52308

D 52308

CERTIFICATE OF DEATH.

REGISTERED NO. 69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Carr

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28 WARD. (Troy N.Y.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 3 mos. 0 ds. How long in U. S., If of foreign birth? 68 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Troy N. York.

PARENTS

10 NAME OF FATHER Joseph D Carr

11 BIRTHPLACE OF FATHER (city or town) Albany (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary Gould.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed APR 1 1921 Robert [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 17th 1914 19..., to Apr 10 19 21, that I last saw h[illegible] alive on Apr 10, 19 21, and that death occurred, on the date stated above, at 10 10 P m.

The CAUSE OF DEATH* was as follows:

Epilepsy-Chronic- (Status Epilepticus abt 5 days)

abt (duration) 25 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Epileptic Mania-

abt (duration) 5 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Troy N. Y

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat-Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Troy N. Y.	Apr 11 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52809 D 52809

CERTIFICATE OF DEATH.

REGISTERED NO. C 92-170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3915 E Pratt ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ceseri Campelli

(Residence in Baltimore: No. 3910 E Pratt St.; 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. fem

4-COLOR OR RACE, wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) marr.

6-DATE OF BIRTH, Aug 22, 1888
(Month) (Day) (Year)

7-AGE, 33 yrs. 7 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Pasquale Candeari

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Donata Russo

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celia Campelli

(Address) 3915 E Pratt

15- Robert P. Harrison,
Dated APR 11 1921, 191...
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10, 1921
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Feb 2 1921, to April 1921, that I saw her alive on april 10 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Labor premature

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY. (Secondary) chronic nephritis

(Duration) 4 yrs. ....mos. ....ds.

(Signed) Felix Testa M. D.

...., 191... (Address) 210 Pearl St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus

DATE OF BURIAL, Apr 12, 1921

20-UNDERTAKER J Kenny & Co

ADDRESS 1400 E Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52810

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Roba

(a) RESIDENCE. No. # 409 S. Paca St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE: Years 28; Months —; Days —; If LESS than 1 day, ... hrs. or ... min. unknown

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Stepan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Eva macutones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant (Address) F. Robu 409 S. Paca St

15 Filed ..... 19..... Robert F. Harrison, Registrar

PR 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to April 9, 1921, that I last saw h.. alive on April 9, 1921, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Pleurisy c Effusion Tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Keyser, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: April 13 1921

20 UNDERTAKER: John Grebliauckas — ADDRESS: 726 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... should be stated TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dampo Hien or Green

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52811 — CERTIFICATE OF DEATH. — 28 — D 52811

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal tuberculosis ST.: [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dampo Hien or Green

(a) RESIDENCE. No. 129 W. Camden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Fedora Hien.

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
26		mokom		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 0420

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Pete Hien.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant P. Green (Address) 129 W Camden St.

15 Filed APR 11 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1921, to April 10, 1921, that I last saw h[illegible] alive on April 10, 1921, and that death occurred, on the date stated above, at 1030 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Arthritis of knee. Unknown. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? T.B. in sputum.

(Signed) L. D. Rigney, M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz cemetery	April 12 1921

20 UNDERTAKER John Grebliunas ADDRESS 425 S Pac[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52812

D 52812

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Portland ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Valentina Duchanek

(a) RESIDENCE. NO. 716 Portland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antony Duchanek

6 DATE OF BIRTH (month, day, and year) Aug 11th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) Scrub Woman

(c) Name of employer Union Trust Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Antony

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorth Knorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr W. J Baker

(Address) 716 Portland st

15 Filed APR 11 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1921, to Apr. 9, 1921, that I last saw her alive on Apr. 9, 1921, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J M Dellett, M. D.

Apr 10, 1921 (Address) 621 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	April 12th 1921
20 UNDERTAKER	ADDRESS
Geo Leimback & Son	647 N Eutaw st

JOSEPH GALLAGHER

Spec.—6-9-19—H. P. Co.—1090 Bks.

D 52813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52813

CERTIFICATE OF DEATH.

54

1-PLACE OF DEATH S. Balto. Gen. Hosp.

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Gallagher.

(a) RESIDENCE. No. 3040 Belmont Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Gallagher

6 DATE OF BIRTH (month, day, and year) Mar. 2, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Provision Broker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Gallagher

11 BIRTHPLACE OF FATHER (city or town) Ireland. (State or country)

12 MAIDEN NAME OF MOTHER Ellen Mullen

13 BIRTHPLACE OF MOTHER (city or town) Ireland. (State or country)

14 Informant South Balto Gen. Hospital (Address) 1213 Light St.

15 Filed ..... 19 ..... Registrar

R 1 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1921, to April 9, 1921, that I last saw him alive on April 9, 1921, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Sphenic Anemia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Post-operative peritonitis.

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? 3040 Belmont Ave.

Did an operation precede death? Yes Date of 3/19/21

Was there an autopsy? .....

What test confirmed diagnosis? Part of condition of spleen, liver, blood picture, peritonitis.

(Signed) L. G. Dobbins, M. D.

19 (Address) S. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 12 1921
20 UNDERTAKER	ADDRESS
Martin Father & Sons	1827 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52314

CERTIFICATE OF DEATH.

37 D 52314

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lemuel T. Braden

(a) RESIDENCE. No. 1718 Guilford Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Conductor on Steam R.R.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jas. Braden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kath. Dibold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lemuel Braden
(Address) 1718 Guilford Ave

15 Filed ..... 19.... Robert P. Harrison, Registrar

R 11 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1915, to 4-11, 1921, that I last saw him alive on 4-11, 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Tabes dorsalis
Arteriosclerosis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia,
myocardial failure (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann

(Signed) W. M. Craig, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	April 14 1921

20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1527 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact street number should state TION is very important. See instructions on back of certificates. of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52815 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52815

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. German Aged Home ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna B. Crabbe

(a) RESIDENCE. NO. German Aged Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 16th 1838

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westmoreland County
(State or country) Virginia

PARENTS

10 NAME OF FATHER Robert H. Crabbe

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Record German Aged Home
(Address) Baltimore & Payson Sts.

15 Filed APR 11 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1920, to April 9th, 1921, that I last saw h.... alive on April 7th, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Contusted Nephritis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptom

(Signed) John H Cuff, M. D.

, 19 (Address) 1843 N. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Apr. 17 19 21
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52816

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52816

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 W. Pratt St. ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia V. Rowley

(a) RESIDENCE. NO. 836 W. Pratt St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward L. Rowley

6 DATE OF BIRTH (month, day, and year) August 26"1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER Lilburn Evans

11 BIRTHPLACE OF FATHER (city or town) Balto. County (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah A. Maxwell

13 BIRTHPLACE OF MOTHER (city or town) Balto. County (State or country) Maryland

14 Informant Edward L. Rowley

(Address) 836 W. Pratt St.

15 Filed APRIL 1921 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11" 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/14/, 1920, to 4/11/, 1921, that I last saw h.er alive on 4/10/, 1921, and that death occurred, on the date stated above, at 1.05 A. a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Intoxal Regurg

History (duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Bernard J. Tenny, M. D.

4/11, 1921 (Address) 910 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Cem (Hampden)	Apr. 14" 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Gallo St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52817 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52817

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Steffey

(Residence in Baltimore: No. Chapel Gate Lane, Ten Hills St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, September 8, 1911
(Month) (Day) (Year)

7-AGE, 11 yrs. 7 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Charles H. Steffey

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Louetta Plitt

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Steffey

(Address) Chapel Gate Lane, Ten Hills

15- Robert P. Harrison,
Filed APR 1 1921, 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident
Fracture Skull
(Duration) yrs. mos. 1hr ds.

CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. 1hr ds.

(Signed) C. E. Blade M. D.
(Coroner.)
April 11, 191... (Address) 4437 Berg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, April 12, 19...

20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52318 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52318

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 130 E Montgomery ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M Foxwell

(a) RESIDENCE. No 130 E Montgomery ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced (or) WIFE of John E Foxwell

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Mr W Pruitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Fanny Ritchie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John E Foxwell
(Address) 130 E Montgomery St

15 Filed Robert P. Harrison, Registrar
4/1 1921 Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from June 23- 1916, to April 8, 1921, that I last saw her alive on April 8, 1921, and that death occurred, on the date stated above, at 8:45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) D E Burton, M. D.

4/9, 1921 (Address) 201 E Conn St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Girdletree - Worcester Co. Md	April 12 1921
20 UNDERTAKER John F. Denny	ADDRESS 715 Eighth St

...at it may be properly classified. Exact statement of ... and the State ...
...TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52819

CERTIFICATE OF DEATH.

50 ✓ D 52819

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Evans

(a) RESIDENCE. No. 810 N Calhoun ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo H. Evans.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emmaline Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Hospital Records New City Hospital

15 Filed ....., 19.... Registrar

R 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 12, 1921, to April 8, 1921, that I last saw h.er alive on April 8, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Obesity

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) Bateman, M. D.

April 9, 1921 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 12 1921
20 UNDERTAKER	ADDRESS 1114 N.
Brown & Fleeland Schroder	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52820 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52820

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1710 Ellamont ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roberta M Mills

(a) RESIDENCE. No 1710 Ellamont ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank D. Mills

6 DATE OF BIRTH (month, day, and year) FEB. 9. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Robb E. Hodgkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alexandria. V.a.

12 MAIDEN NAME OF MOTHER Mary J. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Md

14 Informant Frank D. Mills

(Address) 1710 Ellamont ave

15 Filed Robert P. Harrison, Registrar

R 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Apr. 10 1921, that I last saw her alive on Apr. 10th 1921, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Miliary Tuberculosis)

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) Tuberculosis of hip (Rt) & Rt Elbow

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? Yes Date of Mar 15-1921

Was there an autopsy? No

What test confirmed diagnosis? Lung Examination

(Signed) D. A. Dodder, M. D.

, 19 (Address) 3101 Clifton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
GLENWOOD CEMETRY	April 12 1921
20 UNDERTAKER WASHINGTON. D.C.	ADDRESS Thos Hollins
Robert Brookeson	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk

D 52821

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52821

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 449 East 22nd St.; 12 WARD)

REGISTERED NO. C 168-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Faistenhaner

(Residence in Baltimore: No. 449 East 22nd St.; yrs. 61 mos. 11 ds. 24)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, Nov (Month) 18 (Day), 1859 (Year)

7-AGE,	If LESS than 1 day,
61 yrs. 4 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(h) General nature of industry, business, or establishment in which employed (or employer): NO

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS:

10-NAME OF FATHER, Henry Snyder

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Karl

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. L. Faistenhaner

(Address) 449 E. 22nd

15- APRIL 1921, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas poison

Suicide

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Shuffenmayer M. D. (Coroner.)

April 11 1921 (Address) 1632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	4/13, 1921
20-UNDERTAKER	ADDRESS
William Cook	502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52822 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52822

Information should be stated EXACTLY. PHYSICIANS should indicate

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52822 HEALTH DEPARTMENT—CITY OF BALTIMORE. D 52822

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 Clarkson ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Heinrichs

(a) RESIDENCE. No. 1526 Clarkson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Heinrichs

6 DATE OF BIRTH (month, day, and year) Dec 9th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piano Stringer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katie Heinrichs (Address) 1526 Clarkson st

15 Filed APR 11 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 20, 1921, to April 10, 1921, that I last saw ... alive on April 4, 1921, and that death occurred, on the date stated above, at 7 AM.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) ....yrs. 3 mos. ....ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

4/11, 1921 (Address) 1 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	April 13 1921
20 UNDERTAKER B Schlemmer Son	ADDRESS 1539 Monroe st

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Every item of information is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should state

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52823 HEALTH DEPARTMENT--CITY OF BALTIMORE D 52823

CERTIFICATE OF DEATH

28

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 2102 N. Smallwood ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lola M. Taylor

(Residence in Baltimore: No. 2102 N Smallwood St.; 28 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH: May (Month) 15th (Day), 1892 (Year)

7 AGE: 28 yrs. 10 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Brostrager

11 BIRTHPLACE OF FATHER (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary F Baldwin

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward L. Taylor

(Address) 2102 Smallwood St

15.

Filed APR 11 1921, 191 Robert P. Harrison REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 11 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1920, to April 11 1921.
that I saw h-- alive on April 10, 1921.
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 9 mos. ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) I. H. Broadstein M. D.

April 11, 1921. (Address) 1918 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
London Park Cem	Apr 14th, 1921
20 UNDERTAKER	ADDRESS
J. Schumacher Son	1337 Hanover St

D 52824 HEALTH DEPARTMENT—CITY OF BALTIMORE

155 D 52824

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 712 Edmondson Ave. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Bach

(Residence in Baltimore: No. 712 Edmondson Ave St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, Sept. 28, 1856 (Month) (Day) (Year)

7-AGE, 64 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Herman Moog

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Wilhemina Zimmerman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Minnie Schmoke

(Address) 712 Edmondson Ave

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 9, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide (carbolic acid)

3 hrs.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary).....

(Duration) ....yrs....mos....ds.

(Signed) J. C. Kennedy M. D. (Coroner.)

April 9, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem	April 12th 1921
20-UNDERTAKER E. J. Thomas & Son	ADDRESS 1034 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52825 HEALTH DEPARTMENT—CITY OF BALTIMORE VD 52825

CERTIFICATE OF DEATH. 18

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 Woodbourne Ave 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Campbell

(a) RESIDENCE. No. 603 Woodbourne Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse D. Campbell

6 DATE OF BIRTH (month, day, and year) Jan 10 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md Maryland

PARENTS

10 NAME OF FATHER William Root

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sarah Mumma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs F Helm 603 Woodbourne ave

15 Filed APRIL 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 1st, 1921, to Apr. 10th, 1921, that I last saw her alive on Apr. 9th, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas
old age senile

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Home

(Signed) E. M. Duncan, M. D.

, 19 (Address) 5104 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian cemetery Lutherville Md	April 12 1921

20 UNDERTAKER Chas. S. Black ADDRESS 742 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52826 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 52826

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 Ramsay ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Felte

(a) RESIDENCE. No. 2110 Ramsay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Felte deceased

6 DATE OF BIRTH (month, day, and year) Jan 9 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Weller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Justus Kimmel (Address) 2110 Ramsay St.

15 Filed APR 11 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2 1921 to April 10 1921, that I last saw h... alive on April 9. 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis,

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No. Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) A. M. Dixon M. D.

, 19 (Address) 1733 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 12 1921

20 UNDERTAKER Geo. R. Gerbig ADDRESS 2001 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52827

CERTIFICATE OF DEATH.

99 D 52827

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. Wilkins ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Louise Hibline

(a) RESIDENCE. No. 512 N. [redacted] St. Fairfield Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) dec-23-1860

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Geo Hibline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Agnes Grandelmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Jennie Hibline. (Address) 512 N. Carey St

15 Filed Robert P. Harrison, Registrar

APR 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-23-21, 19...., to 4-9, 1921, that I last saw h.er alive on 4-9, 1921, and that death occurred, on the date stated above, at 5:45 m.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhagic Nephritis

(duration) yrs. mos. 20d ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W M Craig, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 4-12-1921

20 UNDERTAKER H. C. Branning & Son

ADDRESS 527 N Schroeder St

TION is very important. See instructions

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock." "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Infection of Parotid Gland - Cause of infection unknown

D 52328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: City of Baltimore (No. Mercy Hospital St.: 6 Ward) 175-005 ✓

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Mary Howey

(Residence in Baltimore: No. Church Home, St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem'l	White	Widow

6-DATE OF BIRTH. ....Autumn....., 1..... (Month) (Day) (Year)

7-AGE. 85 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE. (State or Country), S C

PARENTS.

10-NAME OF FATHER, Joseph Henry

11-BIRTHPLACE OF FATHER (State or Country), S C

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Hyle

(Address) 2101 Linden ave

15- APR 12 1921 ROBERT J KRAUTER

Filed....., 191..... Registrar.

Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 9 —, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Runaway Accident

Multiple Fractures of

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock, over

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. C. Blake M. D. (Coroner.)

Apr 10 1921 (Address) 1436 Gray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laraine Lee	Apl 12 1921
20-UNDERTAKER Joseph Ahrens	ADDRESS 221 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 52829

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 52829

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua Thomas

(Residence in Baltimore: No. 1524 N Spring St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	W	Single

6-DATE OF BIRTH, March 31st Third, 1888
(Month) (Day) (Year)

7-AGE, 32 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Upholsterer
(b) General nature of industry, business, or establishment in which employed (or empioyer). 085

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Thomas

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elmer Eaton

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Schrader

(Address) 1524 N Spring St

15- Filed APR 12 1921 ROBERT P. KRAUTER Registrar.

Burial Form

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au~~ ~~topsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. R. Jones M. D.
(Coroner.)

4-11, 1921. (Address) 107 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cemetery	April 13, 1921.
20-UNDERTAKER Joseph Ahrens	ADDRESS 221 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 52830 D 52830

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C 120

CITY OF BALTIMORE: (No. 3019 Windsor Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Weller

(Residence in Baltimore: No. 3019 Windsor Ave St.; 54 yrs. 9 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6-DATE OF BIRTH June (Month) 19 (Day) 1866 (Year)

7-AGE 54 yrs. 9 mos. 21 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: House Duties
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE (State or country): Balto. Md

PARENTS

10-NAME OF FATHER: Christian Waldkoenig

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Louisa Gundlach

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis C. Weller

(Address) 3019 Windsor Ave

15- APR 12 1921 Filed ....., 191 ROBERT J. BRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April (Month) 9 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25, 1921, to, Apr 9 1921, that I saw h[er] alive on Apr 9 1921, and that death occurred, on the date stated above, at 6.25 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Adema

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), Adam L Feldpausch M. D.

Apr 10 1921 [Address] 2506 Harlem

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Apr. 12, 1921
20-UNDERTAKER	ADDRESS
Mr - Mrs J. W. Teufel & Son	801 W. Fayette

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Cathy Meyer.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52831

CERTIFICATE OF DEATH.

74 D 52831

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 N. Castle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cathy Meyer

(a) RESIDENCE. No. 1821 N. Castle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 28, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	14	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Klebe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary Meyer
(Address) 1821 N. Castle

15 APR 12 1921 ROBERT P. KRAUTER
Filed ....., 19 .....
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 10, 1921, that I last saw h.. alive on April 9, 1921, and that death occurred, on the date stated above, at 1.20 p m.

The CAUSE OF DEATH* was as follows:

Degeneration of Intestines.

Life (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mal-Nutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Apr 10 1921 (Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Apl 12 1921
20 UNDERTAKER	ADDRESS
Mrs Mrs J. W Tempel & Son	501 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52832

D 52832

CERTIFICATE OF DEATH.

92 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 E Preston ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Barker Pitt

(a) RESIDENCE. No. 200 E. Preston ST., 11 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Pitt Jr.

6 DATE OF BIRTH (month, day, and year) Apr 24 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia Gosling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant C. Gordon Pitt
(Address) 200 E. Preston St

15 Filed APR 12 1921 19 ROBERT B. BRAUTIGAM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4 1921, to April 10, 1921, that I last saw him alive on April 10, 1921, and that death occurred, on the date stated above, at 10 15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Bronchial Asthma

(duration) 8-10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) A. F. Robinson, M. D.

4/11, 1921 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	4-12 1921

20 UNDERTAKER Henry W. Jenkins Sons Co ADDRESS Orchard and McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 52833

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Allen ST.: 23 WARD)

2-FULL NAME Frank J. Svoboda

(a) RESIDENCE. NO. 1427 Allen ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara M. Svoboda

6 DATE OF BIRTH (month, day, and year) Dec 20. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. (all)

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER John. Svoboda.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Marii Kosnek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Clara M. Svoboda (Address) 1421 Allen.

15 Filed APR 12 1921 ROBERT B. BRAUNS Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to April 10, 1921, that I last saw him alive on April 9, 1921, and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ....yrs. ....mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. J. Gluckman, M. D.

4/12 1921 (Address) 1 E Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.C. DATE OF BURIAL 4/13 1921

20 UNDERTAKER J. Few McCully ADDRESS 1305 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52834

CERTIFICATE OF DEATH.

2479 D 52834

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 638 E. Clement St. St.: ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Clara E. Schwabeland

(a) RESIDENCE. No. 416 E. Fort Avenue St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? 60 yrs. 11 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Schwabeland

6 DATE OF BIRTH (month, day, and year) Apr. 16, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 07

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John T. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz. J. McCracken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant: Mrs. Clark,
(Address) 638 E. Clement St.

15 Filed APR 12 1921 Burial Permit Issued by ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 9 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1921, to April 9, 1921, that I last saw h... alive on April 9, 1921, and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm. L. Stigler, M. D.

19 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	4/12 1921
20 UNDERTAKER	ADDRESS
J. Fenwick McCully	130 E. Fay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 52835

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 111 W. Hughes St. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Ottis.(C)

(Residence in Baltimore: No. 111 W. Hughes St. 8 St.; yrs., mos. ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. ...ly classified. Exact statement of OCCUPATION is very ...ly supplied. AGE ...

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH, ... Do not know. (Month) ....., 1 (Day) ..... (Year)

7-AGE, 33 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hours or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, George Ottis.(C)

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Ottis.(C)wife.

(Address) 111 W. Hughes St.

15- Filed APR 12 1921, 191... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 11th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....Inquiry.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ....inquiry.... find that said deceased came to ....his.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.
Pulmonary Hemorrhage.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt M. D.
(Coroner.)

April 11 1921 (Address) 1917 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Ct	April 13 1921
20-UNDERTAKER	**ADDRESS**
J. H. Brown & Son	1082 W. Monty St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52836

CERTIFICATE OF DEATH.

151 D 52836

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 W. Montgomery ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Brooks

(a) RESIDENCE. No. 112 W. Montgomery ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 28. 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER David Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eleanor Harmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eleanor Brooks
(Address) 112 W. Montgomery st

15 Filed APR 12 1921 [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1921, to April 11, 1921, that I last saw her alive on April 10, 1921, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

"Inanition" resulting from Premature Birth (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D. Harwell, M. D.

4/11, 1921 (Address) 1400 W. Hill st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn St	April 12 1921

20 UNDERTAKER J. E. Brown & Son ADDRESS 107 N. Monty

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1732 D 52837 / D 52837

CERTIFICATE OF DEATH.

30

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin Smith.

(a) RESIDENCE. NO. 570 E. 26th St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 2½ ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4-1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child. gdd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md.

PARENTS

10 NAME OF FATHER Frank Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Fanny Quantin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) France.

14 Informant. Johns Hopkins Hospital Records
(Address)

15 Filed APR 12 1921 [illegible] Registrar

Burial Permit Olark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1921

17

I HEREBY CERTIFY, That I attended deceased from April 5 , 1921 , to April 11 , 1921 ,

that I last saw him alive on April 11 , 1921 ,

and that death occurred, on the date stated above, at 12.22 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No Floyd

What test confirmed diagnosis? T.B. bacilli spinal

(Signed) Horton Caspares M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	April 13 1921
20 UNDERTAKER	ADDRESS
Chenowith Son	Preston St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52838

D 52838

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1425 Madison Ave. ST. 14th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY LEILAND CASTELLAW

(a) RESIDENCE. NO. 1425 Madison Ave. ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	widowed.

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Charles F. Castellaw

6 DATE OF BIRTH (month, day, and year) Mar 25 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
-	33		15.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. Old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greenville S. C. South Carolina.

PARENTS

10 NAME OF FATHER — Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant George E. Blaser (Address) 114 Park Ave. Atlanta Ga.

15 Filed APR 12 1921 19.. ROBERT J. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I ~~hereby~~ CERTIFY, That I attended deceased from ~~March 15~~ 1921, to April 10 1921, that I last saw h 4 alive on April 10 1921, and that death occurred, on the date stated above, at 7. 15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Whitehouse, M. D.

19 (Address) 1342 W Lanvale Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Apl 12 21
20 UNDERTAKER	ADDRESS
Ehenworth & Son	Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 52839

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 W 25th St. ST.; 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie E Phillips

(a) RESIDENCE. NO. 807 W 25th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 30 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Phillips

6 DATE OF BIRTH (month, day, and year) Feb 6 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Williams Grose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles F. Phillips (Address) 807 W 25th St

15 Filed APR 12 1921 In ROBERT A CRAIGEN Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1921

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1920, to Apr 11, 1921, that I last saw her alive on Apr 11, 1921, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) J. Saunders Wood, M. D.

4/12 1921 (Address) 846 W 36th & 847 Booth,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	April 14 1921
20 UNDERTAKER	ADDRESS
Cohenour & Son	Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 52840

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3507 Greenmount Av. ST.; 9 WARD)

2-FULL NAME Anna C. Lorenz

(a) RESIDENCE. NO. 3507 Greenmount St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late John Lorenz

6 DATE OF BIRTH (month, day, and year): Apr 17-45

7 AGE — Years: 75 Months: 11 Days: 23 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Betz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Lorenz
(Address): 3507 Greenmount St

15 Filed APR 12 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to April 10, 1921, that I last saw h[illegible] alive on April 10, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Arteria-Sclerosis-Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Alma B Lemon, M. D.

(Address) 7188 Pulaski Hy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Apr 12 1921

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52841 ✓ D 52841

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 W Preston ST.; 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anne DeCoursey

(a) RESIDENCE. No. 509 W Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard DeCoursey

6 DATE OF BIRTH (month, day, and year) abt. Sept 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Nicholas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Melinda Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hester Scott (Sister)

(Address) 509 W. Preston St.

15 Filed APR 12 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1921

17

I HEREBY CERTIFY, That I attended deceased from March 25, 1921, to April 9th, 1921, that I last saw h[illegible] alive on April 8th, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Brights Disease

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine Examination

(Signed) Samuel A Bonn, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mt. Auburn Cemetery	Apr. 12 1921
20 UNDERTAKER Jno. W. Johnson	ADDRESS 1204 Etting St.

IMPORTANT. PHYSICIANS should state DISEASE OR CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52842 D 52842

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 N Gilmor ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Archer Abbott

(a) RESIDENCE. No. 1127 N Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Regina E Abbott.

6 DATE OF BIRTH (month, day, and year) May 9 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Leesburg Va

PARENTS

10 NAME OF FATHER Joseph Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elysburg City U.S.

12 MAIDEN NAME OF MOTHER Mary E Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Leesburg Va

14 Informant Regina E Abbott
(Address) 1127 N Gilmor St

15 Filed APR 12 1921 ROBERT F KRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 9, 1921, to Apr 10, 1921, that I last saw him alive on Apr 10, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ac. Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure

(Signed) Jno Talbot, M. D.

, 19 (Address) 1353 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Apr 13 1921

20 UNDERTAKER Putnam & Sons ADDRESS 1123 W Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 156-001 D 52843

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1430 n Bethel St. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura V Parsons

(Residence in Baltimore: No. 1430 n Bethel St. 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOW(ER), OR DIVORCED. (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, Sept 15, 1871
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
49 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House 03
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country) Canada Eng

PARENTS.

10-NAME OF FATHER, Isaac Stobbart

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Anna M Porter

13-BIRTHPLACE OF MOTHER (State or Country), Carlow Ire

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma L Brouch

(Address) 132 N Carrollton

15-

Filed APR 12 1921 191 ROBERT P. KRAUTH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) D J Kelly M. D.
(Coroner)
4-11-22, 192. (Address) W. P. Sta

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Md.	Aug 13, 1921
20-UNDERTAKER, Robt J Turner Jr	ADDRESS 1744 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52844

CERTIFICATE OF DEATH.

105 D 52844

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 N. Dallas ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolores F. Cox

(a) RESIDENCE. No. 1824 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 7/19/1917

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Theresa Huffnagle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Thomas Cox
(Address) 1824 N. Dallas St.

15 Filed APR 12 1921 ROBERT J. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from April 9— 1921, to April 10 1921, that I last saw her alive on April 10— 1921, and that death occurred, on the date stated above, at 6-15 P. m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) E. Gill Hall, M. D.

(Address) 1617 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 13 1921

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 52845

CERTIFICATE OF DEATH.

39 D 52845

REGISTERED NO.

1-PLACE OF DEATH St. Agnes Hosp

CITY OF BALTIMORE: (No. ~~1934 N. Hope st~~ ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Layton

(a) RESIDENCE. NO. 1934 Hope ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? ~~yrs.~~ mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Emma B Layton

6 DATE OF BIRTH (month, day, and year) Jan. 16 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer 057

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Frank Layton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs Emma Layton
(Address) 1934 N. Hope st

15 Filed APR 12 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-12-21, 19..., to 4-9-21, 19..., that I last saw him alive on 4-9-21, 19..., and that death occurred, on the date stated above, at 11.05 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue
With Metastasis to
Glands of neck.

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema -

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? yes Date of ?

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic test

(Signed) W. M. Craig, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Apr 13 21
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave

TION is very important. See instructions on back of certificates.

Spec.—8-9-19—H. P. Co.—1000 Bks.

D 52846

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

41 D 52846

1-PLACE OF DEATH Bay View Gate House — REGISTERED NO.

CITY OF BALTIMORE: (No. Eastern Ave & 11th St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Dicke

(a) RESIDENCE. NO. New City Hosp. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of Husband of Lida Dicke

6 DATE OF BIRTH (month, day, and year) Dec 7-1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gate Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Dept

(c) Name of employer Balto - City

9 BIRTHPLACE (city or town) (State or country) Balto - Md.

PARENTS

10 NAME OF FATHER Leonard Dicke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Lida Dicke
(Address) Bay View Asylum Eastern Ave & 11th St.

15 Filed ..., 19 ... Registrar

APR 12 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-9 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1920, to Apr. 9, 1921, that I last saw h[illegible] alive on Apr. 8, 1921, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia & Cachexia (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Sept. 15, 1920

Was there an autopsy? No.

What test confirmed diagnosis? Exploratory oper.

(Signed) J. A. Hilden, M. D.

4-11, 1921 (Address) New City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state: (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Holy Redeemer	4/7 1921
20 UNDERTAKER	ADDRESS
C. F. Evans & Co	418 N. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52847 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 52847.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Orleans ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. H. Washington.

(a) RESIDENCE. No. 1315 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col.	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia Washington

6 DATE OF BIRTH (month, day, and year) Dec. 14-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. Washington

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Draper

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Julia Washington
(Address) 1215 Orleans St.

15 Filed APR 12 1921 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to April 8, 1921, that I last saw him alive on April 8, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

4-11, 1921 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Apr. 13 1921

20 UNDERTAKER	ADDRESS
Chas. H. Strauss	467 N. Carlin

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52848 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 52848

120 D 52848

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay Vist. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Monroe

(a) RESIDENCE. NO. ~~Unknown~~ 422 n Poppleton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 yr	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 APR 12 1921 ROBERT A KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1921 to April 11, 1921.

that I last saw him alive on April 10, 1921.

and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows: Chronic Diffuse Nephritis

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Chronic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No special test.

(Signed) Jack R. Morgan, M. D.

4/11/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	4,14, 1921
20 UNDERTAKER Mrs Chas B Jones	ADDRESS 211 n Pine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3811 Clifton ave. ST.: 15 WARD)

REGISTERED NO. 78

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Rodgers Jr

(a) RESIDENCE. No. 3811 Clifton ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mrs Elsie Rodgers

6 DATE OF BIRTH (month, day, and year) April 5 1865

7 AGE — Years: 55 — Months: 11 — Days: 27 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clk. insurance Co

(b) General nature of industry, business, or establishment in which employed (or employer): Clk Insurance Co

(c) Name of employer: Fidelity & Deposit Co

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George H Rodgers Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary E. S. Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Proctor Rodgers
(Address): 3811 Clifton

15 Filed: APR 12 1921 — ROBERT I. HEAVEN, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1921, to Apr. 11, 1921, that I last saw him alive on Apr. 11, 1921, and that death occurred, on the date stated above, at 2 0 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Acute dilitation of heart (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. S. Niblett, M. D.

Apr. 11, 1921 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Apr. 13 1921

20 UNDERTAKER: John B. Spence — ADDRESS: 1320 N. Caroline St

TION is very important. See instructions on back of certificates. ay be properly classified. Exact statement of OCCUPA- ...should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52850

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 52850

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp. ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lynch. (Mary A. Lynch)

(a) RESIDENCE. NO. 1444 Mount Pelier ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? Lifelong mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph A. Lynch

6 DATE OF BIRTH (month, day, and year) Sept. 18 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER James Gilfoil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McNally

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr Joseph A. Lynch

(Address) 1444 Mountpelier St

APR 12 1921

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7 1921, to April 11 1921, that I last saw h alive on April 11 1921, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Coronary Left Artery. About 1918

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 11.

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J. J. Sullivan M. D.

. 19 (Address) St Josephs Hosp Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: Apr. 14 1921

20 UNDERTAKER: Henry Hoeck Son

ADDRESS: 1301 E Eager

MEDICAL CERTIFICATE OF DEATH should state plainly, legibly and in ink, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Backless Polite

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52851

CERTIFICATE OF DEATH.

28 D 52851

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis St. [illegible] WARD 11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Backless Polite

(a) RESIDENCE. No. 1024 Wheatcroft ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Sandy Polite

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Maria Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant Julius C. Polite (Address) 1024 Wheatcroft St.

15 Filed APR 12 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1921, to April 8, 1921.

that I last saw him alive on April 8, 1921.

and that death occurred, on the date stated above, at 10.56 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) two yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Tb in sputum

(Signed) L. J. Rigney, M. D.

, 19 (Address) Municipal Tb hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr-12 1921
20 UNDERTAKER	ADDRESS
Edward Quigley	1763 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52852

CERTIFICATE OF DEATH.

79 D 52852
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor, 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice - Helfrich

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Helfrich.

6 DATE OF BIRTH (month, day, and year) about 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland, Md.

PARENTS

10 NAME OF FATHER John King.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Easter Florence
(Address) Preston & Valley

15 Filed APR 12 1921 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1921

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..., to No record, 19...,
that I last saw her alive on April 9, 1921,
and that death occurred, on the date stated above, at 10.15 a. m.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia & Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Warner, M. D.
April 11, 1921 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cumberland Md.	4/13/21
20 UNDERTAKER	ADDRESS
Maugt & Thym	14 N Eutaw

CAUSE OF DEATH must be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mc Comas

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52853

CERTIFICATE OF DEATH.

28 D 52853

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3005 Grayson st ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Joseph McComas Jr

(a) RESIDENCE. No. 3005 Grayson st ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 26, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Frank J. McComas Sr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Rull

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant M. Frank J. McComas
(Address) 3005 Grayson st

15 Filed APR 12 1921, 19.... BOYER S KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 6th, 1921, to April 11th, 1921,
that I last saw h— alive on April 11th, 1921,
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. 2 ds.

CONTRIBUTORY .....
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) Jno Clifford Hill M. D.
(Address) 401 E 20th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	April 13 1921

20 UNDERTAKER Jos. J. Herr ADDRESS 156 N. Luzerne ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52854

CERTIFICATE OF DEATH.

10-04

D 52854

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Hagerty ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Kane

(a) RESIDENCE. No. 2005 Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 7-1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER — Wm Kane

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER — Martha Koch

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mother Martha Kane
(Address) 2005 Hanover St.

15 Filed APR 12 1921 ROBT. P. PRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1921, to April 10, 1921, that I last saw h[illegible] alive on April 10, 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Septic Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 3 ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. O. Whelan, M. D.

April 12, 1921 (Address) 1299 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Co.	April 13, 21
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St

NAME OF DECEASED should state PLAINLY AND DISTINCTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52855

CERTIFICATE OF DEATH.

152 D 52855

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 S. Bouldin ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Johnson

(a) RESIDENCE. No. 827 S. Bouldin ST., 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frederick Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss.

12 MAIDEN NAME OF MOTHER Annie O'Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

11 Informant Fred. Johnson
(Address) 827 S. Bouldin St.

15 Filed APR 12 1921 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1921, to April 12, 1921, that I last saw him alive on April 12, 1921, and that death occurred, on the date stated above, at 12 35 a.m.

The CAUSE OF DEATH* was as follows:

Probable Umbilical Cord.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Warren B Tilton M. D.

4/12, 1921 (Address) 525 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. Harford Av.	April 12 1921
20 UNDERTAKER	ADDRESS
Lilly and Zeller.	403 S. Wolfe St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52856

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Carrollton Ave ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Rea

(a) RESIDENCE. NO. 808 N. Carrollton Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 10. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas H. Rea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annie Mullan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. C. W. Keech

(Address) 808 N. Carrollton Ave.

15 Filed APR 12 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1921, to April 10, 1921, that I last saw him alive on April 10, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) Edgar C. Sandrock, M. D.

, 19 (Address) 15 W. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	4-14 1921
20 UNDERTAKER	ADDRESS 517 W.
H. C. Brannon & Son	Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52857

CERTIFICATE OF DEATH.

28 D 52857

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 S. Eutley. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Tecto.

(a) RESIDENCE. No. 620 S. Eutley. ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawrence Tecto.

6 DATE OF BIRTH (month, day, and year) May 12th 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 837

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Morris Shields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary McEarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Lawrence Tecto.
(Address) 620 S. Eutley St.

15 Filed APR 12 1921 ROBERT J. KLAUER Registrar

Postal Transit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1918, to Apr 9, 1921, that I last saw her alive on Apr 9, 1921, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. 5 mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination Sputum

(Signed) A L Tumbleson, M. D.

4/11 1921 (Address) 2013 Banks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	April 13 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 4033 Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52858

D 52858

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2218 Gough ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthias J. Vogel

(a) RESIDENCE. NO. 2218 Gough St ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Vogel

6 DATE OF BIRTH (month, day, and year) May 14 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stripping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Laceys Foundry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John D. Vogel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Katharine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Margaret Vogel
(Address) 2216 Gough St

15 Filed APR 12 1921, 19 ROBERT F. BEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 - 1920, to Apr - 10 - 1921, that I last saw him alive on April - 9 - 1921, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Intestinal), (duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis (duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William H. Johnson M. D.

4/11, 1921 (Address) 2016 Guilford ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	April 13 1921
20 UNDERTAKER	ADDRESS
Lilly Feiler	1100 S. Holl...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52859

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh Brooks

(a) RESIDENCE. No. 512 Preston st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced BUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Reamer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Silas Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Manda ??

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant (Address) UNIVERSITY OF MARYLAND,

15 Filed ....., 19.... Robert P. Harrison, Registrar

APR 12 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to April 8, 1921, that I last saw him alive on April 8, 1921, and that death occurred, on the date stated above, at 8.25 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous broncho pneumonia (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum.

(Signed) J. Riggs, M. D.

4-8-21, 19.... (Address) Municipal Tuc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 1921

20 UNDERTAKER Commissioner Health, Wm. S. WOODALL

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52860 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52860

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1911 Ridgewood ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby James Harris.

(a) RESIDENCE. NO. 1911 Ridgewood ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10-1921

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Harris

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Nettie Albecker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

11
Informant
(Address) Robert P. Harrison JOHNS HOPKINS HOSPITAL

15 Filed APR 12 1921, 19
Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17
I HEREBY CERTIFY, That I attended deceased from April 10, 1921, to April 10, 1921, that I last saw h/m alive on April 10, 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Prematurity -
(26 wks fœtus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature rupture of Amniotic membranes (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

4-11, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	APR 13 1921

20 UNDERTAKER Commissioner Health. ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52861

D 52861

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH Baltimore City.

CITY OF BALTIMORE: (No. 2615 Huntington Ave ST.; 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby McDade

(a) RESIDENCE. No. 2615 Huntington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 11-1921

7 AGE	Years	Months	Days	If LESS than 1 day 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Bernard McDade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jennie McCabe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant
(Address)

15 Filed ....., 19 Registrar
[Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1921, to April 12, 1921, that I last saw him alive on April 11, 1921, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6½ mos.)

None (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. W. Ingram, M. D.

, 19 (Address) 2430 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: NS HOPKINS HOS...

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health,
Wm. F. WOODALL

APR 1 1921

APR 12 1921

D 52862

D 52862

Spec.—6-8-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 Hanover ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvator Cicero

(a) RESIDENCE. NO. 735 Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angelina Cicero

6 DATE OF BIRTH (month, day, and year) July 27-1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vincent Cicero

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosario

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Cicero

(Address) Robert P. Harrison

15 Filed , 19 Registrar

Apr 12 10 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 10 1921

17

I HEREBY CERTIFY, That I attended deceased from April, 7, 1921, to April, 10, 1921, that I last saw h. alive on April, 10, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Consultation

(Signed) Dan'l Francklin, M. D.

4/17 1921 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	April 13 1921
20 UNDERTAKER	ADDRESS
F. A. Fraver & Son	737 Hanover

TION is very important. See instructions on back of certificates.

D 52863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52863

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Chesapeake Bay on S.S. Argus,

CITY OF BALTIMORE (No. now at Pier 6 Locust Point. ST.: 24 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Luke A. Weber.

(Residence in Baltimore: No. Michigan. St.; yrs., mos., ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH, ..Do not know.., 1 ..
(Month) (Day) (Year)

7-AGE, ..27.. yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..Oiler on S.S. Argus.
(b) General nature of industry, business, or establishment in which employed (or employer) ..Argus, D..

9-BIRTHPLACE, (State or Country), Michigan.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..Capt. F.O. Evans.

(Address) ..S.S. Argus Pier 6 Locust Point.

15- Robert P. Harrison,

Filed ..... 191.....
Registrar.

APR 12 1921

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..April 9th, 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..inquiry.. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..inquiry.. (Inquest, autopsy or inquiry.) find that said deceased came to ..his.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of an Aortic Aneurism.
Unknown.
(Duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..yrs. ..mos. ..ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

April 12, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Marine City Mich.

19-PLACE OF BURIAL OR REMOVAL, Marine City Mich. Via am Ry Express. DATE OF BURIAL, April 13 1921

20-UNDERTAKER John A. Denny ADDRESS 715 Light St

Whether or not Cystic is unknown

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage.*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

146 909 D 52864

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

909 D 52864

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Ehler

(a) RESIDENCE. No. 1407 W Fayette St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... brs. or ..... min.
		7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leroy Ehler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Irene Brook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London England

14 Informant ..... (Address) Hospital Record J. H. H.

15 Filed APR 12 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10-1921

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1921, to April 10, 1921, that I last saw him alive on April 10, 1921, and that death occurred, on the date stated above, at 1 00 P. m.

The CAUSE OF DEATH* was as follows:

Rickets and Tetany

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Nasal Diphtheria, Bronchopneumonia 2 wks 1 day.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

4-11, 1921 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 12 1921

20 UNDERTAKER (ADDRESS)

W. A. Tuttle 2 E Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52865

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 28

CITY OF BALTIMORE (No. 1525 Jackson St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas White.

(Residence in Baltimore: No. 1525 Jackson St. 12 ---------. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, January 12, 1886, (Month) (Day) / (Year)

7-AGE, 35 yrs. 3 mos. --- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brakeman 67
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R.R. Co.

9-BIRTHPLACE, (State or Country), Barnesville Md.

PARENTS.

10-NAME OF FATHER, Howard White.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Alice B. Trundle.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L. White (brother).

(Address) 1st & Van Buren Sts N.W. Washington D.C.

15- Robert F. Harrison,

Filed APR 12 1921, 191 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 12th, 1921, (Month) (Day) 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

April 12th 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Barnesville Md	April 13, 1921
20-UNDERTAKER	ADDRESS
E. J. Fanning	1140 Battery Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52866 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52866

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Mann St.; WARD)

2-FULL NAME Caroline Hardiman

(a) RESIDENCE. No. 2 Mann St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 3 mos. 27 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emmit McHardiman

6 DATE OF BIRTH (month, day, and year) Dec 16-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Stapf

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Kate Kellner

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Louise E Knapp
(Address) 218 E Barnes St

15 Filed APR 12 1921 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30 1921, to April 11, 1921, that I last saw h.r alive on April 9, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Thompson, M. D.

1921 (Address) 19 E. Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 14 1921

20 UNDERTAKER F. B. Kilpatrick ADDRESS 2216 Eutaw Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52867

CERTIFICATE OF DEATH.

64 D 52867

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 Ramsey ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Kratz

(a) RESIDENCE. No. 2123 Ramsey ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? —yrs. —mos. —ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Kratz

6 DATE OF BIRTH (month, day, and year): Sept 3rd 18[illegible]

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Casper Koehler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Julia Steinwedel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Harry Kratz (Address) 2123 Ramsey St

15 Filed APR 12 1921 19.. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1921, to April 11, 1921, that I last saw h[illegible] alive on April 10 1921, and that death occurred, on the date stated above, at 4 30 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

Arteriosclerosis

(duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Endocarditis & Pulmonary Edema (duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Kratz, M. D.

(Address) 2151 Hutchins ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 14/21
20 UNDERTAKER	ADDRESS
F. D. Hispert	2236 Fred'k

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52868

HEALTH DEPARTMENT---CITY OF BALTIMORE.

CERTIFICATE OF DEATH

79 D 52868

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. Falls Rd. St. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Anne E. Reilly

(Residence in Baltimore: No. Same St.; 2 yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: W

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Dec 10 (Month) (Day), 1852 (Year)

7-AGE: 68 yrs. 4 mos. 2 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Nil
(b) General nature of industry, business, or establishment in which employed (or employer): ood

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: [illegible] Bailey

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: [illegible] Tracy

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. J. Reilly

(Address) Falls Rd. Mt. Washington

15- APR 13 1921 Filed ....., 191 ROBERT J. BEAUTE Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 4/12 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April, 1913, to, 4/12 1921, that I saw h[illegible] alive on 4/12 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Uremia

10 (Duration) Sudden mos. ds.

Contributory (SECONDARY) Fatty degen. Heart Muscle (Duration) yrs. mos. ds.

(Signed) Henry F. Covey M. D.

4/12, 1921 (Address) Roland Park

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 5 yrs. mos ds. In the State 5 yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St. Mary's (Govans) DATE OF BURIAL: April 14 1921

20-UNDERTAKER: Horace Burgee Son ADDRESS: 3631 Falls Road

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52869

CERTIFICATE OF DEATH.

47

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 E Lombard ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexandria Forrest

(a) RESIDENCE. No. 1605 E Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth. Forrest.

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Daniel Forrester

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Ruth Forrest (Address) 1605 E Lombard St

15 Filed APR 13 1921 19 ROBERT J. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to April 10, 1921, that I last saw h[illegible] alive on April 8, 1921, and that death occurred, on the date stated above, at 11 50 a.m.

The CAUSE OF DEATH* was as follows:

mitral Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) articular Rheumatism

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Frohn, M. D.

4-19-21 (Address) 1612 E monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery, April	13 1921

20 UNDERTAKER Milton Davis & W. E. Edelen | ADDRESS S.D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52870

CERTIFICATE OF DEATH.

79 D 52870

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 460 Brunswick ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith B. Wirth

(a) RESIDENCE. No. 460 Brunswick ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 18, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John A. Wirth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER May Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John A Wirth
(Address) 460 Brunswick

15 Filed APR 13 1921, 19 ROBERT P. BRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to April 10, 1921, that I last saw her alive on April 10, 1921, and that death occurred, on the date stated above, at 9.37 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Theo Neill M. D.

4/11, 1921 (Address) 108 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Cathedral	April 14 1921

20 UNDERTAKER John J Fields ADDRESS 1700 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

no further history

Spec.—6-9-19—H. P. Co.—1000 Bks.

52871

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52871

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 Slingluff Ave. WARD) 15

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A Hewitt

(a) RESIDENCE No. 1738 Slingluff Ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? U.S. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Hewitt

6 DATE OF BIRTH (month, day, and year): Aug 5/1874

7 AGE — Years: 46 — Months: 8 — Days: 7

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer): 084

(c) Name of employer: Charles Grant

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph A Hewitt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rachel Cathe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Katherine Hewitt

(Address): 1738 Slingluff Ave

15 Filed APR 13 1921 19.. ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1919, to March 13 1921, that I last saw h.. alive on March 12, 1921, and that death occurred, on the date stated above, at 3.20 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 20 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. Clemens M. D.

4/13/21 (Address) 2757 Whitmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: April 15 '21

20 UNDERTAKER: W. M. Cockey & Nattans — ADDRESS

TION is very important. See instructions on back of certificates.

...y be properly classified. Exact statement of OCCUPA-

...in plain terms, so that it may be

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 52872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 52872

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 West 40th St. 13 WARD)

2-FULL NAME Virginia A Williams

(a) RESIDENCE. No. 1011 West 40th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widow

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Wm. Williams

6 DATE OF BIRTH (month, day, and year) Aug 11/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Henry Simonds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Susan Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs. T. J. Arthur 2917 Gilmore Lane

15 Filed APR 13 1921 19 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4th, 1921, to April 11, 1921, that I last saw her alive on April 11, 1921, and that death occurred, on the date stated above, at 10:12 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus
Albuminuria at hand & Pneumonia

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? yes Date of April 6-21

Was there an autopsy? no

What test confirmed diagnosis? Exam of urine

(Signed) Wm Smith, M. D.

, 19 (Address) 3429 Clarkson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 14. 1921
20 UNDERTAKER	ADDRESS
Pete Boat	5086 Reisterstown Rd

IMPORTANT. PHYSICIANS should state plainly the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2 don

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52873

CERTIFICATE OF DEATH.

40

D 52873

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 Fred'k St. ST.: 20 WARD)

2-FULL NAME Chas B. Seton

(a) RESIDENCE. No. 1905 Fred'k St. ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs C B Seton

6 DATE OF BIRTH (month, day, and year) Jan 9-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker 88

(b) General nature of industry, business, or establishment in which employed (or employer) Shoemaker

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Belgium

PARENTS

10 NAME OF FATHER Edmond Seton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belgium

12 MAIDEN NAME OF MOTHER Emelie Trecot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Belgium

14 Informant Julia Seton (Address) 1905 Frederick Ave

15 Filed ..... 19 ..... ROBERT E KRAUTH Registrar APR 13 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1921, to Apr 10, 1921, that I last saw h. alive on Apr 10, 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hamon Baker M. D

(Address) 3027 W Mt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Apr. 13 1921
20 UNDERTAKER	ADDRESS
Geo H Schwab & Bro	201 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52874

HEALTH DEPARTMENT—CITY OF BALTIMORE

154 D 52874

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Whittemore Ave. St. Violetville WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Knieling

(a) RESIDENCE. No. 21 Whittemore Ave ST., ... WARD. .....
(Usual place of abode). (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Friedrich Knieling

6 DATE OF BIRTH (month, day, and year) Jan 18-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Johann Bieber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Bieber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Fred Knieling

(Address) 21 Whittemore Ave

15 Filed APR 13 1921 19.... Registrar

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) Apl 10 1921

17 I HEREBY CERTIFY, That I attended deceased from January 15, 1921, to Apl 10, 1921, that I last saw h.. alive on April 10, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia of age

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Jno Car Dill, M. D.

Apl 17 1921 (Address) 1433 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Apr. 13 1921
20 UNDERTAKER	ADDRESS
Geo. Lehmat & Bro	2111 Pratt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52875

CERTIFICATE OF DEATH.

28 D 52875

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 Glyndon Ave 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily K. Martin

(a) RESIDENCE. No. 1320 Glyndon Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Martin

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	not known	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Anton Zelnar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Antonina Litwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Anthony J. Martin
(Address) 1320 Glyndon ave.

15 Filed APR 13 1921 19 ROBERT I. FELDER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to April 10, 1921, that I last saw her alive on Feb 10, 1921, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anthrax

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Joseph E. Muse, M. D.

April 11, 1921 (Address) 1520 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 14 1921
20 UNDERTAKER	ADDRESS
Chas Grebliunckas	1255 Pacific St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52876 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 52876

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3 Fair Oaks Ave (St.) 27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Deracy Fleming

(a) RESIDENCE. No. 3 Fair Oaks Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Fleming

6 DATE OF BIRTH (month, day, and year) Feb 11 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dirk Lamb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dirk Lamb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Willy Fleming (Address) 3 Fair Oaks Ave

15 Filed APR 13 1921 ROBERT F. KEATER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1924

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1919, to April 11, 1921, that I last saw h.. alive on April 11, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

1. Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry A. Long, M. D.

, 19, (Address) 27 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md.	April 1921
20 UNDERTAKER	ADDRESS
H M Routson	2238 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52877

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52877

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Dolphin ST.: 17 WARD)

2-FULL NAME Clement A Bauer.

(a) RESIDENCE. No. 714 Dolphin ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Binder

(b) General nature of industry, business, or establishment in which employed (or employer) 067

(c) Name of employer Government

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bridget Uhlhorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E. Bauer. Wife

(Address) 714 Dolphin St.

15 Filed APR 13 1921

16 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3d, 1920, to April 11th, 1921, that I last saw him alive on April 11th, 1921, and that death occurred, on the date stated above, at 7-20 p. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) Samuel A Bain, M. D.

19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedra	April 15 1921

20 UNDERTAKER Martin Fahey - Sons ADDRESS 1927 W Fayette St

TION is very important. See instructions on back of certificates.

that it may be properly classified. Exact statement of OCCUPA-

PHYSICIANS should state

D 52878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20 D 52878

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos Gourlod.

(Residence in Baltimore: No. 2532 1/2 Druid Hill Ave St.; 1 yrs., 1/2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

Married

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, ~~WIDOWED,~~ OR DIVORCED, (*Write* the word.)
M.	White	

6-DATE OF BIRTH, [illegible] (Month) (Day) 1901 (Year)

7-AGE,	If LESS than 1 day,
29 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Street Car
(b) General nature of industry, business, or establishment in which employed (or employer) Conductor

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Gudger Gourlod.

11-BIRTHPLACE OF FATHER (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Mary McGahey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Donaldson

(Address) 911 N. Fremont St.

15- APR 13 1921 ROBERT A. LAUTER

Filed ..... 191.....

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diphtheria & Infective Throat

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Sticks

(Duration) yrs. mos. ds.

(Signed) Geo. E. Blake M. D.
(Coroner)

4/13/21 191... (Address) 140 N. Exeter

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters Cem.	April 14, 1921
20-UNDERTAKER	ADDRESS
Martin Fahrenholz	1329 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52879

CERTIFICATE OF DEATH.

137

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Loretto Dougherty -

(a) RESIDENCE. NO. 1515 W. Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Dougherty

6 DATE OF BIRTH (month, day, and year) Jan 2nd 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34 yrs	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Andrew Dougherty

(Address) 1515 West Pratt

15 Filed APR 13 1921 ROBERT F. BEAUTER Registrar

Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-11, 1921, to 4-12, 1921, that I last saw h.. alive on 4-12, 1921, and that death occurred, on the date stated above, at 12 00 M. m.

The CAUSE OF DEATH* was as follows:

Infection - puerperal sepsis

Pulmonales & peritonitis

Streptococcus

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Toxemia eclampsia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Craig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral cemetery	April 15 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1005 Park Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52880

CERTIFICATE OF DEATH.

80 D 52880

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 E. Preston ST.: 9 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Kelly

(a) RESIDENCE. No. 1104 E. Preston ST., WARD.

(Usual place of abode) Lifetime.

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary E. Kelly.

6 DATE OF BIRTH (month, day, and year) April 12-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) City Engineer's

(c) Name of employer Department.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James W. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Broderick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E. Kelly (Address) 1104 E. Preston St.

15 FILED APR 13 1921 ROBERT A. CRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1921, to April 12, 1921, that I last saw him alive on April 10th, 1921, and that death occurred, on the date stated above, at 2.8 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? — None

(Signed) Albertus Cotton, M. D.

4/13 1921 (Address) 1303 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL 4/15 1921

20 UNDERTAKER Chas. F. Evans & Son ADDRESS 1107 W. Mt. Royal Ave

IT IS THE DUTY of every person having knowledge of a death to report it to the Health Department. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52881

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto., Gen. Hosp. ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. W. Powell

(a) RESIDENCE. No. 1224 Rankin place Balto., Md. ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Powell

6 DATE OF BIRTH (month, day, and year) June 27-1844

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	79 ~~80~~	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer-retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo W. Powell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Drusila Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mary Powell 1227 Rankin Place

15 Filed R 13 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-7-21, 19..., to 4-13-21, 19..., that I last saw him alive on 4-13-21, 19..., and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chr. parenchymatous Nephritis

Arteriosclerosis -

Tumor in epigastrium

Type undetermined -

Unable to get history and

no urine obtainable.

X-Ray did not show the tumor

18 Where was disease contracted, if not at place of death? Time of admission

Did an operation precede death? No (Wife invalid) Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood pressure & Phy exam.

(Signed) W. Johnson, M. D.

(Address) So Balto., Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: April 16 1921

20 UNDERTAKER: F. B. Keppert — ADDRESS: 2236 Fredk Ave

IMPORTANT.—Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52882

CERTIFICATE OF DEATH.

169

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin & Emory Hospital St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Taylor

(Residence in Baltimore: No. 1821 Vine St.: yrs., 61 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, April (Month) 11 (Day), 1856 (Year)

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Steward
(b) General nature of industry, business, or establishment in which employed (or employer): 0.1

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Taylor

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lillie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Augusta Taylor

(Address) 1821 Vine St

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

PR 131921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock following

operation (Duration) ..... yrs. ..... mos. 2 hrs ds.

(Signed) James M. Fenlon M. D.
(Coroner.)

April 12 1921 (Address) 300 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1821 Vine St

Former or usual residence 1821 Vine St

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Woodlawn	April 14 1921
20-UNDERTAKER Brown & Sheeland	ADDRESS 117 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate. ... should be stated EXACTLY. PHYSICIANS should write

Spec.—8-24-14—M. & T.—2000 Bks.

Chas A Riemer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52883

CERTIFICATE OF DEATH.

170 D 52883

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2711 Fait ave. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlie L. Riemer

(Residence in Baltimore: No. 2711 Fait St.; 40 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Nov. 27, 1857 (Month) (Day) (Year)

7-AGE. 63 yrs. 4 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Painter & ...
(b) General nature of industry, business, or establishment in which employed (or employer). ...

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Fred. Riemer

11-BIRTHPLACE OF FATHER (State or Country). Ger.

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (State or Country). Ger.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Riemer

(Address) 2711 Fait ave.

15- APR 14 1921 ROBERT J. BRAUER

Filed ..... 191.... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 11, 1921 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 19 1921, to April 11 1921, that I saw h[illegible] alive on March 21 1921, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatitis Nature Not Stated

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hepatic Complication

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. C. Heer M. D.

April 12, 1921 (Address) 402 E Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. St. Matthews Cem. DATE OF BURIAL. April 14, 1921.

20-UNDERTAKER Jos. J. Herr ADDRESS 156 N. Luzerne ave.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52884 ✓ D 52884

CERTIFICATE OF DEATH.

113

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Druid Hill ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Jamison

(Residence in Baltimore: No. 1124 Druid Hill Ave St.; 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 184 (Year)

7-AGE, 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Memphis Tenn

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John D. McKim

(Address) 1124 Druid Hill Ave

15- APR 14 1921 Filed....., 191.... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 14th 1917, to Apr 12 1921, that I saw h in alive on Apr 11 1921, and that death occurred, on the date stated above, at 1:20 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

..... (Duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None Known

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. J. Keller M. D.

Apr 13th, 1921. (Address) 222 W Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, April 14, 1921

20-UNDERTAKER Samuel T Hemley — ADDRESS 678 W. Biddle St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified. Exact statement of CAUSE OF DEATH is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52885

CERTIFICATE OF DEATH.

28 D 52885

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 E. 31st st. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beverley T. Lener

(a) RESIDENCE. No. 309 E. 31st st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Susie H. Lener

6 DATE OF BIRTH (month, day, and year) July 11. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50 yrs	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Sign Co

9 BIRTHPLACE (city or town) (State or country) Shenandoah Va

PARENTS.

10 NAME OF FATHER Henry C. Lener

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Isabella Catherine Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Susie H. Lener
(Address) 309 E. 31st st.

15 Filed APR 14 1921 Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1st 1921, to April 12 1921, that I last saw him alive on April 11th 1921, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 months 0 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. found in Sputum

(Signed) Wilbert Webb, M. D.

(Address) 3006 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 14 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens Sons	217 S. Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Schreiber

D 52886

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 ✓ D 52886

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Notre Dame Convent St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Evarista Schreiber

(Residence in Baltimore: No. Aisquith St & Ashland Ave St.; 33 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... March (Month) 10 (Day), 1856 (Year)

7-AGE,	If LESS than 1 day,
65 yrs. 1 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), New York N.Y.

PARENTS.

10-NAME OF FATHER, Peter Schreiber

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Rank

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Dionede

(Address) Aisquith & Ashland Ave

15- APR 14 1921 ROBERT I KRAUTER

Filed....., 191.....

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 5 1921, to April 13 1921, that I saw her alive on ..... 1921, and that death occurred, on the date stated above, at 3.50 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis ✓
Uraemic Convulsions

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. F. Kelly M. D.

April 13, 1921. (Address) 1102 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Notch Cliff Md.	April 15 1921
20-UNDERTAKER	**ADDRESS**
Frank A. Fink	915 N. Gay St

important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

Boone

D 52887 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 52387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Clifton Park ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Boone

(Residence in Baltimore: No. Clifton Park St.: 0 yrs., 7 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, October 18, 1836 (Month) (Day) (Year)

7-AGE, 84 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Keeper Lake Roland (1884) (retired)
(b) General nature of industry, business, or establishment in which employed (or employer): Balto City Co

9-BIRTHPLACE, (State or Country) Hampden Baltimore Md

PARENTS.

10-NAME OF FATHER, A. Boone

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas H. Boone

(Address) Clifton Park

15- APR 14 1921 Filed....., 191.... ROBERT J. KRAJEWSKI Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 12, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from about 1911, to April 12 1921, that I saw him alive on April 11 1921, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

About (Duration) 10 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Right Hemiplegia

(Duration) 1 yrs. 9 mos. 3½ ds.

(Signed) William F. Ford M. D.

Apl 12, 1921 (Address) 1417 Eutaw Pl. Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 58 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Lake Roland

19-PLACE OF BURIAL OR REMOVAL Greenmount Cemetery — DATE OF BURIAL, Apr 14, 1921

20-UNDERTAKER H. A. Marshall — ADDRESS 3539 Lal. Rd

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52888

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 D 52888

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1454 W. 36 St ST.; 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Jones

(Residence in Baltimore: No. 1454 W. 36 St St.; 40 yrs., — mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Oct. 15, 1880
(Month) (Day) (Year)

7-AGE, 75 yrs. 5 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) Rod & Knife

9-BIRTHPLACE, (State or Country). Balto Co.

PARENTS.

10-NAME OF FATHER, Andrew Jones

11-BIRTHPLACE OF FATHER (State or Country). Balto Co.

12-MAIDEN NAME OF MOTHER Mary A Bowen

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Margaret R. Jones

(Address) 1454 W 36 St

15- APR 14 1921 ROBERT S. ATAUER
Filed....., 191.... Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1920, to April 12 1921, that I saw h[illegible] alive on April 12 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 4 ds.

(Signed) W. S. Smith M. D.

4/13, 1921 (Address) 3429 Chestnut Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Mary's DATE OF BURIAL. Apr. 15, 1921

20-UNDERTAKER A. S. Marshall ADDRESS 3539 Fall Rd

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52889

D 52889

X 38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1512 Brunt ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lucy Ireland

(a) RESIDENCE. NO. 1512 Brunt ST., WARD. Atlantic City NJ

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Co	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Ireland

6 DATE OF BIRTH (month, day, and year) Sept 4. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife of Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Cook-Washing Mch

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) St Marys Co. Md

PARENTS

10 NAME OF FATHER Wiley Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary Co.

12 MAIDEN NAME OF MOTHER Mary Jane Westfall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co

14 Informant Mary Jane West.

(Address) 1512 Brunt St

15 Filed APR 14 1921 ROBERT I. KRAVER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1920, to April 13, 1921, that I last saw h alive on April 11, 1921, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Pelvic Cellulitis

Post Operative Abscess - Rt Side

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Anaemia 2 ORW

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Atlantic City N.J.

Did an operation precede death? yes Date of July 1920.

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wright, M. D.

(Address) 1709 Orchard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 15 1921
20 UNDERTAKER David Easton	ADDRESS 916 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

D 52890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52890

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH Women's Hospital

CITY OF BALTIMORE: (No. Lafayette & Johns St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy V. Williams.

(Residence in Baltimore: No. The Plaza, Wilson St & Park. St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Sept 1 X, 1846. (Month) (Day) (Year)

7-AGE, 75 yrs. 8 mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country). Williamsburg Va.

PARENTS.

10-NAME OF FATHER, John R Armistead

11-BIRTHPLACE OF FATHER (State or Country), Petersburg Va

12-MAIDEN NAME OF MOTHER Eaton.

13-BIRTHPLACE OF MOTHER (State or Country), Williamsburg Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ella Williams Cohen

(Address) Vanderbilt Apts. Conn. Ave

15-

Filed APR 14 1921, 191.... ROBERT J. BRADHAM Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 13, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 7 1921, to Apr. 13 1921, that I saw her alive on Apr. 13. 191..., and that death occurred, on the date stated above, at 6.10 A m.

The CAUSE OF DEATH* was as follows:

Ac Pyelonephritis

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 4 9 ds.

(Signed) Frank Dewitt Mitchell M. D.

April 13, 1921. (Address) Women's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 17 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence The Plaza, Park & Wilson Sts Park.

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Apr 14, 1921.

20-UNDERTAKER J. H. MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 52891

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Weinberger

(a) RESIDENCE. No. 535 W. Barre St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 35 yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
---

6 DATE OF BIRTH (month, day, and year) 1840 May 12th

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Weinberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed APR 14 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to April 12, 1921, that I last saw her alive on April 11, 1921, and that death occurred, on the date stated above, at 6:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) F. A. Holden, M. D.

4/12/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	apr 14 1921
20 UNDERTAKER	ADDRESS
Mr. Mrs J. W. Teufelsson	801 N. Fayette

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52892 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 52892

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2109 McCulloh ST.; 14 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. N. Friedland

(Residence in Baltimore: No. 2109 McCulloh St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1872 (Year)

7-AGE, 49 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer (General)
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Calvert Co, Md,

PARENTS.

10-NAME OF FATHER, Jim Freeland.

11-BIRTHPLACE OF FATHER (State or Country) Maryland.

12-MAIDEN NAME OF MOTHER Auburn

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas H. Thomas

(Address) 2109 McCulloh St

15- Filed APR 14 1921 ROBERT B KRAUTER Registrar. BUREAU OF VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April (Month) 12 (Day) ....., 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pulmonary Tuberculosis

..... (Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) No history

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. D. Hennessy M. D.
(Coroner.)

April 13 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	April 14 19....
20-UNDERTAKER John N. Tradin	ADDRESS 1742 Mt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52893

CERTIFICATE OF DEATH.

4V D 52893

REGISTERED NO.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Name of disease should be stated EXACTLY. PHYSICIANS should state

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 E. Monument St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Burrell

(a) RESIDENCE. No. 1633 E Monument St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Rowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) John H. Burrell 1633 E. Monument.

15 FILED APR 14 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1921, to April 13, 1921, that I last saw h alive on Apr 12, 1921, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix Uteri

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no July 1919

What test confirmed diagnosis? microscopic

(Signed) J. Edward Johnson M. D.

4-13-1921 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetary	April 15 1921
20 UNDERTAKER	ADDRESS
Chas B. Bailey	142 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 52894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ OK! HK Gorsuch

186 former no. D 52894

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; 19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Gleason Anderson

(a) RESIDENCE. No. 532 N Pleasant Hosp St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: J. Brennan & Son

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Armon Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Robert G Anderson
(Address): 322 n Gilmor St

15 Filed APR 14 1921 19 ROBERT F KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-29, 1921, to 4-10, 1921, that I last saw h[illegible] alive on 4-10, 1921, and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Fract. of Femur. Tibia & Fibula on left side. Fract of rt patella (simple)

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): Typhoid Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? accident -

Did an operation precede death? Yes Date of 4-1-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jabez Taylor, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: April 13/21

20 UNDERTAKER: John H Todd — ADDRESS: 142 Hill St

CAUSE OF DEATH in plain terms, so that it may be [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 52895

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST.; W WARD)

2-FULL NAME Marie Costello

(a) RESIDENCE. NO. Temple Court Apt. ST., City WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank J Costello

6 DATE OF BIRTH (month, day, and year) June 9 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22.	10.	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Harry J Dunlea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant F J Costello
(Address) 1916 E Lafayette Ave

15 APR 14 1921 ROBERT J KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/ 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 13, 1921, that I last saw her alive on April 13, 1921, and that death occurred, on the date stated above, at 345 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical symptoms & Symptoms

(Signed) Chas. H. A. Meyer, M. D.

, 19 (Address) 1021 N Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 16 1921
20 UNDERTAKER E. L. Fanning & Son	ADDRESS 1938 E Lafayette Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52896

CERTIFICATE OF DEATH.

120 D 52896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 819 Brice ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Eugenie Wilhelm

(a) RESIDENCE. NO. 819 Brice st ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Louis A. Wilhelm

6 DATE OF BIRTH (month, day, and year) March 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	67	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nothing

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Glanding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Laura Armiger
(Address) 819 Brice st.

15 Filed APR 14 1921 19 ROBERT A. LAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13- 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4 1921, to April 13 1921, that I last saw h.r alive on April 13 1921, and that death occurred, on the date stated above, at 4.45 P.m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ...yrs. 9 hours mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopic exam.

(Signed) J. Thos. Nelson, M. D.

19 (Address) 1001 N. Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	April 15 1921

20 UNDERTAKER Josiah Lefler ADDRESS 1600 N. Howard

CAUSE OF DEATH in plain terms, so that it may be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 52897

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. D 52897

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Gilmor ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. McGee

(a) RESIDENCE. NO. 1424 Gilmor ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 8 Nov 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Edward Magee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER E Babington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

14 Informant Ella M Magee

(Address) 1424 N Gilmor St

15 Filed APR 14 1921 ROBERT P. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 15 1921 to April 13 1921; that I last saw him alive on April 12 1921; and that death occurred, on the date stated above, at 11.30a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Basilar)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Left side paralyzed

(Signed) Charles E. Clark M. D.

4-14 1921 (Address) 4306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cathedral	April 16 1921
20 UNDERTAKER	ADDRESS
Frank Speer	1600 W North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52898 ✓

D 52898 CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay Vist. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Bucks

(a) RESIDENCE. No. 1704 E. Fort Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ernest Bucks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed APR 14 1921 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1921 to April 11, 1921, that I last saw him alive on April 10, 1921, and that death occurred, on the date stated above, at 8:35 A. m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) V. B. Herman, M. D.

4/11/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL APR 15 1921 19

UNIVERSITY OF MARYLAND

20 UNDERTAKER Commissioner Health. ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52899

CERTIFICATE OF DEATH.

91-089

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 797 St. Peter ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert C George

(Residence in Baltimore: No. 797 St. Peter St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 5 (Day), 1920 (Year)

7-AGE, ...yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John C. George

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Alberta Clayton

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John C. George

(Address) 797 St. Peter st

15-

Burial Permit [illegible]

Filed APR 14 1921

Robert P. Harrison, Registrar.

N.B.—Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 13 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 12 1921, to Apr 13 1921, that I saw him alive on Apr 13 1921, and that death occurred, on the date stated above, at 430 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) ....yrs. ....mos. 10 ds.

(Signed) A. C. Fullinger M. D.

4/14/21, 1921 (Address) 682 Park ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Fork cemetery Balto Co. DATE OF BURIAL, April 15, 1921.

20-UNDERTAKER James Dignan & Son ADDRESS 1000 S. Paca st

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52900

CERTIFICATE OF DEATH.

114 D 52900

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Jefferson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard H. Kettlewell

(Residence in Baltimore: No. 2021 Jefferson St ... St.; 60 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Dec 25, 1845
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
75 yrs. 7 mos. 18 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman do
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Peter Kettlewell

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Catherine J Kettlewell

(Address) 2021 Jefferson St

15-

Filed APR 14 1921, 191... Robert F. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 11 1921, to April 13 1921, that I saw h~~im~~ alive on April 13 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Heart failure cause
by Gall stone colic

(Duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. H. Bagby M. D.

4/14/21, 191... (Address) 709 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore County	April 15, 1921

20-UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison Ave

Burial Permit Clerk.

Dr Gage 709 N Broadway

IMPORTANT. Causes of DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

147260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52901

D 52901

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Figiel.

(a) RESIDENCE. No. 629 S. Kenwood Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. / How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

Unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Frances Figiel (mother)

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1864.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	3	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H-Work. 037

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Philip Pirnik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia Czerwinski.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant (Address) Johns Hopkins Hospital. Records

15 Filed Robert P. Harrison, Registrar

R141921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1921

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 13, 1921, that I last saw her alive on April 13, 1921, and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

? (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Operation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 4/10/21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible] M. D.

4-13, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	April 16 1921
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated

Spec.—6-2-19—H. P. Co.—1000 Bks.

D 52902 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3801 Fernwood Ave 26 WARD) 79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Shepherd

(a) RESIDENCE. NO. 3801 Fernwood Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Shepherd

6 DATE OF BIRTH (month, day, and year) Jan 5-1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) a.a Co. Md.

PARENTS

10 NAME OF FATHER Robert Eades

11 BIRTHPLACE OF FATHER (city or town) (State or country) a.a.Co Md

12 MAIDEN NAME OF MOTHER Mary Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) a.a.Co Md

14 Informant Matilda Shipps

(Address) 3801 Fernwood Ave

15 Filed Robert P. Harrison, Registrar

APR 14 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 7, 19 21, to Apr 12, 19 21, that I last saw h[illegible] alive on Apr 12, 19 21, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam

(Signed) Geo C Radcliffe, M. D.

, 19 (Address) 143 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Apr 15 1921
20 UNDERTAKER	ADDRESS
Geo. Schwab & Bro	201 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 640 N. Carrollton Ave ST.; 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah P. Leckie

(a) RESIDENCE. No. 640 N. Carrollton ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 1843

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
77	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Princess Ann Maryland

PARENTS

10 NAME OF FATHER: Samuel D. Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah A. Lankford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John Gould Leckie
(Address): 640 N. Carrollton ave

15 Filed: Robert P. Harrison, Registrar

APR 14 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 18th 1920, to April 13th 1921, that I last saw h~~e~~ alive on April 13th 1921, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary -

(Signed) Stephen F. Stillman, M. D.

April 14 21 (Address) 1227 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: East New Market Md

DATE OF BURIAL: April 15 1921

20 UNDERTAKER: Chas. G. Black

ADDRESS: 742 W. North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 52904

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N. Payson ST.; 16 WARD)

2-FULL NAME Theresa M. Armstrong.

(a) RESIDENCE. No. 811 N. Payson ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo Armstrong.

6 DATE OF BIRTH (month, day, and year): Mar 6 1872

7 AGE: Years 49 Months Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Alex Topps

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: A. Woodenhoff.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs Bertha Epstein

(Address) 811 Payson St

15 Filed Robert P. Harrison, Registrar

APR 14 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to April 13, 1921, that I last saw h[illegible] alive on April 12, 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Arc. V. Desophagus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? No.

What test confirmed diagnosis? Desophagoscope

(Signed) S. M. D. Schwartzbury M. D.

, 19 (Address) 1120 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 1921
UNDERTAKER: H. Kuehnert & Sons	ADDRESS: Norman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52905

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 52905

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wade

(a) RESIDENCE. No. 330 Dover St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER George Wade

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Mary Emile

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant (Address) UNIVERSITY OF MARYLAND.

15 Filed ... 19 ... Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/9 1921, to 4/10 1921, that I last saw h— alive on 4/10 1921, and that death occurred, on the date stated above, at 11.02 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Card. Dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lewis L. Rudy M. D.

4/10 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL ... 19

20 UNDERTAKER Commissioner Health, per Wm. F. WOODALL — ADDRESS

APR 14 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52906

154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Druid Hill St.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Araminta Salisbury

(Residence in Baltimore: No. 1215 Druid Hill St.; 80 yrs., 1 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, May 3, 1841
(Month) (Day) (Year)

7-AGE, 80 yrs. 1 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... do

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Abraham Hyman

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Biddle

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mattie Fax Bdaughter

(Address) 1215 Druid Hill

15-

Filed APR 14 1921, 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 31 1921, to Apr 12 1921, that I saw her alive on Apr 12 1921, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ....yrs. 3 mos. ....ds.

(Signed) H. P. Hughes M. D.

....., 191... (Address) 765 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery — DATE OF BURIAL, Apr. 15, 1921

20-UNDERTAKER John M. Johnson — ADDRESS 1234 Eutaw St.

Be sure CAUSE OF DEATH is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52907

HEALTH DEPARTMENT—CITY OF BALTIMORE

89

D 52907

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1615 Lancaster ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CECILIA BIENKOWSKI,

(a) RESIDENCE. No. 1615 Lancaster ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb-16.1919.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or..... min.
	2	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.,

PARENTS

10 NAME OF FATHER Antoni Biemkowski,

11 BIRTHPLACE OF FATHER (city or town) Kossw,
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Wladislawa Desnizak,

13 BIRTHPLACE OF MOTHER (city or town) Marszej,
(State or country) Poland,

14 Informant Antoni Bienkowski, (Father)
(Address) 1615 Lancaster Street

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

R141921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 14 - 1921

17 I HEREBY CERTIFY, That I attended deceased from March 25th, 1921, to April 14th, 1921, that I last saw her alive on ....., 1921, and that death occurred, on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis (Primary)

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L. Wimmer, M. D.

4-14, 1921 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem	April 16 1921
20 UNDERTAKER	ADDRESS
M. J. Sadowski,	705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52908

CERTIFICATE OF DEATH.

28 D 52908

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1357 W. Stricker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Garrett

(Residence in Baltimore: No. 1357 W. Stricker St.: 14 yrs., 11 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, April (Month) 17 (Day), 1906 (Year)

7-AGE,	If LESS than 1 day,
14 yrs. 11 mos. 24 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... ddo.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Samuel Gray

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lillie Garrett

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Johnson

(Address) 1357 W. Stricker St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

APR 14 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1920, to April 11th 1921, that I saw h[er] alive on April 9th 1921, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

.....Fibroid Phthisis.....

.....

..... (Duration).....yrs.....6.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....A Lee Ellis.....M. D.

Apr. 12, 1921. (Address) 924 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Apr. 15, 1921.

20-UNDERTAKER Edward Ruggold — ADDRESS 1463 Carey St

Be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52909

CERTIFICATE OF DEATH.

28 D 52909

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Pressman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adele Alton

(a) RESIDENCE. No. 1614 Pressman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20 - 1916

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
4	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Calvert County Maryland.

PARENTS

10 NAME OF FATHER: Joshua Alton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert County Maryland

12 MAIDEN NAME OF MOTHER: Priscilla Isaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert County Maryland.

14 Informant: Joshua Alton
(Address): 1614 Pressman St.

15 Filed Apr 14 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

R 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1924

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1921, to April 11, 1921, that I last saw her alive on April 3, 1921, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary): none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 1705 Pressman St.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Chester Riland, M. D.

4-12, 1924 (Address) 2532 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Apr 15 1924
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52910

CERTIFICATE OF DEATH.

120 D 52910

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Braddish Ave ST. 16 WARD)

2-FULL NAME Henry Kraatz,

(a) RESIDENCE. No. 1505 Braddish Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Kraatz,

6 DATE OF BIRTH (month, day, and year) July 30.1835

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ger. W. Little (Address) 2700 Edmondson Ave

15 Filed 19 Robert P. Harrison, Registrar

R 1 4 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 14 - 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to Apr 14, 1921, that I last saw him alive on Apr 12 1921, and that death occurred, on the date stated above, at 7:30 am.

The CAUSE OF DEATH* was as follows:

Chronic nutes Stitis

Nephritis (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) 682 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	April 16th 2

20 UNDERTAKER Geo W Little ADDRESS 2700 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50

D 52911

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Ellamont ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma P.Dean,

(a) RESIDENCE. No. 1612 Ellamont ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances H.Dean,

6 DATE OF BIRTH (month, day, and year) Jan.12.1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co.Md.

PARENTS

10 NAME OF FATHER James Fwoks,

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emma Patterson,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Margery Moore
(Address) 1612 Ellamont Ave

15 Filed Robert P. Harrison, Registrar
APR 14 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1921

17 I HEREBY CERTIFY, That I attended deceased from April 9th, 1921, to April 13, 1921, that I last saw her alive on April 12th, 1921, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carbuncles

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary Test

(Signed) Herbert E. Zepp, M. D.

April 15 1921 (Address) 3050 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL April 16 1921

20 UNDERTAKER Geo W Little

ADDRESS 2706 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52912

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 Wilcox St. 10 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Grogan

(a) RESIDENCE. No. 1004 Wilcox St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. 075

(c) Name of employer Not Known

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Grogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Quill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Michael McKeever (Address) 1004 Wilcox St

15 Date APR 14 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12 1924

17 I HEREBY CERTIFY, That I attended deceased from April 11th, 1921, to April 12th, 1921, that I last saw him alive on April 11th, 1921, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) L. M. C. Barker, M. D.

April 13th, 1924 (Address) 1114 Hartman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

New Cathedral Temp. April 16 1924

20 UNDERTAKER — ADDRESS

Elmer W. Conklin 2246 Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52913

CERTIFICATE OF DEATH.

117-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Hesse

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed APR 14 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1921, to April 13, 1921,

that I last saw her alive on April 12, 1921,

and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis
(Cause undetermined)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Apr. 9, 1921

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Holden, M. D.

4/13/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL April 16 - 1921

20 UNDERTAKER William Cook

ADDRESS 502 E. Hatt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for Intestinal Obstruction but died not found sh.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52914

CERTIFICATE OF DEATH.

92 D 52914

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1266 Ark. Ave ST.: 21 WARD)

(Columbia)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Eugene Earl Childs

(a) RESIDENCE. No. 1266 Ark. Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Walter R Childs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Linda Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter R Childs
(Address) 1266 Ark Ave

15 Filed Robert P. Harrison, Registrar

I 4 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1921, to April 13, 1921, that I last saw him alive on April 13, 1921, and that death occurred, on the date stated above, at 1-30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Typ

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. K. Mc Meaker, M. D.

. 19 (Address) 24 E Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	April 15 1921
20 UNDERTAKER	ADDRESS
Wm Cook	802 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 52915

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2877 W. Lafayette ST.; 16 WARD)

2-FULL NAME Julia A Evans

(a) RESIDENCE. No. 2877 W Lafayette ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William T. Evans

6 DATE OF BIRTH (month, day, and year) Feb 17 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 07

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt.

PARENTS

10 NAME OF FATHER Zakariah Jacobs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm F Smith
(Address) 2877 W Lafayette

15 Filed ..., 19...

Robert P. Harrison, Registrar

Burial Permit Clerk.

APR 14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 6" 1920, to April 12" 1921, that I last saw h.. alive on April 12" 1921, and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes and Nephritis (Chronic)

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Ischemia

(duration) yrs. 5 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Examination

(Signed) Hubert E. Zepp, M. D.

4/14 1921 (Address) 305-0 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 15 1921
20 UNDERTAKER	ADDRESS
Wm Cook.	502 N Gay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Cummings

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52916

CERTIFICATE OF DEATH.

28 D 52916

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE: (No. 527 S. Charles St., ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Addie B. Cummings

(Residence in Baltimore: No. 527 S. Charles St., St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, March 6 -, 1896.
(Month) (Day) (Year)

7-AGE. 25 yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Tilghmans Island Md.

PARENTS.

10-NAME OF FATHER, Albert T. Mister

11-BIRTHPLACE OF FATHER (State or Country), Tilghmans Island Md.

12-MAIDEN NAME OF MOTHER Elizabeth Hateway

13-BIRTHPLACE OF MOTHER (State or Country), Whitman Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert T. Mister

(Address) 527 S. Charles St

15-

Filed..... 191... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15th, 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15th, 191 21, to April 15th, 1921, 191..., that I saw her alive on April 15th, 1921, 191..., and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. Culbreth M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Tilghmans Island	April 15, 191...
20-UNDERTAKER William Cook	ADDRESS 502 E. North Ave.

APR 1921

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52917

CERTIFICATE OF DEATH.

28 D 52917

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie B. Lee

(a) RESIDENCE. No. 821 Sterling st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4yrs. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) live in Balt-4 year South Carolina

PARENTS

10 NAME OF FATHER Milton Vance

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Etta ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records (Address) M.T.H.

15 Filed APR 15 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apirl 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1921, to April 12, 1921, that I last saw her alive on April 12, 1921, and that death occurred, on the date stated above, at 5.18 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. H. Fahnestock, M. D.

4-13-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Apl. 15. 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 725- Dallas St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 52918

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

D 52918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 506 Ogsdan ST.: 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeanette Newman

(Residence in Baltimore: No. 506 Ogsdan St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, August 8, 1920
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 8 mos. 6 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....none.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Daughter.....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Charles Newman

11-BIRTHPLACE OF FATHER (State or Country) Wash. D. C.

12-MAIDEN NAME OF MOTHER Jeanette Snider

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. Newman

(Address) 506 Ogsdan St.

15- APR 15 1921 ROBERT J. KRAUTER
Filed....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Gastro-Enteritis

(Duration) Yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) none known

(Duration) yrs. (mos.) ds.

(Signed) J. P. Hennessy M. D.
(Coroner.)

April 14 1921. (Address) 2802 Edgewood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	April 15, 1921
20-UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D 52919

REGISTERED NO. 79 D 52919

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3304 Clifton Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elijah Jefferson Bond

(a) RESIDENCE. No. 3304 Clifton Ave ST. 15 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 75 yrs. 2 mos. 22 ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Peters Bond

6 DATE OF BIRTH (month, day and year): Jany-23-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attorney-at-Law.

(b) General nature of industry, business, or establishment in which employed (or employer): Law Office

(c) Name of employer: Self Bel-Air - Maryland

9 BIRTHPLACE (city or town) (State or country): Wm. B. Bond

PARENTS

10 NAME OF FATHER: Wm. B. Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known Maryland

12 MAIDEN NAME OF MOTHER: Charlotte H. Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known Maryland.

14 Informant: Mr Wm. B Bond - (son)
(Address): 3304 Clifton Ave

15 Filed APR 15 1921 19 BOYER & FRANKEL Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): apr 14/21 19

17 I HEREBY CERTIFY, That I attended deceased from apr. 1, 1921, to apr. 14, 1921,
that I last saw him alive on apr 13, 1921,
and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis —
Myocarditis —
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. S. Willett, M. D.

Apr. 14/21 19 (Address) 2221 Green Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Apr 16 1921.

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52920

CERTIFICATE OF DEATH.

X 40 D 52920

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 Eutaw Place ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Frank Bond

(a) RESIDENCE. NO. 1210 Eutaw Place ST., 11 WARD. (Ruxton Md)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? 61 yrs. 3 mos. 27 ds.

CAUSE OF DEATH must be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Levering Bond

6 DATE OF BIRTH (month, day, and year) Dec-16-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President of the

(b) General nature of industry, business, or establishment in which employed (or employer) B. F. Bond

(c) Name of employer Paper Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Geo. L. Bond

11 BIRTHPLACE OF FATHER (city or town) Bristol (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Livingston

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mr B. F. Bond Jr. (Son)

(Address) 33 - Hanover St

15 Filed APR 15 1921 ROBERT A. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1920, to April 12th, 1921, that I last saw him alive on April 12th, 1921, and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) ~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 4th 1920

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) M. M. Dabney, M. D.

19 (Address) Ruxton Baltimore Co Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Apr 15 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52921

CERTIFICATE OF DEATH.

64 D 52921

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Homewood av ST.: 9 WARD)

2-FULL NAME Katherine Wade

(a) RESIDENCE. NO 2000 Homewood av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Wade

6 DATE OF BIRTH (month, day, and year) Dec 2 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Youngman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Chas Wade

(Address) 2000 Homewood av

15 Filed APR 15 1921 ROBERT I KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4, 13, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to April 13, 1921, that I last saw h.r alive on April 13, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia one

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Senile Degeneration

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Anne Arundel Co

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Hugh Forsythe, M. D.

, 19 (Address) 424 E. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 15 1921
20 UNDERTAKER	ADDRESS
E A Windsfeld Jr	501 E 22 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52922

CERTIFICATE OF DEATH.

D 52922

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 Edgevale Road St.; Roland Park 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hermine Louisa Hoen

(Residence in Baltimore: No. 602 Edgevale Road St.; Life ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED,~~ OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, October (Month) 4 (Day), 1854 (Year)

7-AGE, 66 yrs. 6 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. August Hoen

11-BIRTHPLACE OF FATHER (State or Country). Duchy of Nassau, Germany

12-MAIDEN NAME OF MOTHER Carolina V. Muth

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert B. Hoen

(Address) Biddle & Chester Sts.

15- Balto. Md.

FILED APR 15 1921 19.....

ROBERT I. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH April (Month) 13 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 14 1921, to April 13 1921, that I saw her alive on April 13 1921, and that death occurred, on the date stated above, at 2.10 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 7 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Right hemiplegia

(Duration) 3 yrs. ... mos. ... ds.

(Signed) William S. Todd M. D.

April 14, 1921. (Address) 1307 Washington Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, April 16 1921

20-UNDERTAKER C. A. Bredfeldt

ADDRESS 501 E. 22nd St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52923

CERTIFICATE OF DEATH.

35 D 52923

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Edmondson Avenue ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Knorr

(a) RESIDENCE. No. 1017 Edmondson Avenue ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 27 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Dec. 7, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles J. Knorr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Augusta Stuart.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Helen M. Knorr
(Address) 1017 Edmondson Avenue

15 Filed APR 15 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 26 -, 1921, to Apl 13 -, 1921,
that I last saw her alive on Apl 13 -, 1921
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:

Generalized
Tuberculosis
(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (Over)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Shepard & Pratt Hosp
Did an operation precede death? Yes Date of About Jany 1-21
Was there an autopsy? No
What test confirmed diagnosis? Yes, Microscopical Exam. Blood
(Signed) E. A. Knorr, M. D.
19 (Address) 1727 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	4/16, 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52924 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52924

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 E. 20th St. ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harry Norris Myers

(a) RESIDENCE. NO. 1109 E 20th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Marion G. Murphy

6 DATE OF BIRTH (month, day, and year) Feb. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) Agent. 680

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rebecca H. Rieder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Marion A. Myers

(Address) 1109 E. 20th St

15 Filed APR 15 1921 [illegible]

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14th 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct., 1920, to April 14th, 1921, that I last saw h.. alive on April 14th, 1921, and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) General Debility

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms, History, Examination

(Signed) J. A. Chatard, M. D.

Apr. 15, 1921 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Apr. 18 1921
20 UNDERTAKER	ADDRESS
Henry Horck Son	1301 E Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52925

CERTIFICATE OF DEATH.

45 D 52925

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 Hollins St. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew W. Donoghue

(a) RESIDENCE. No. 1035 Hollins St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 3" 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Donoghue

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Connolly

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mr. George A. Brennan
(Address) 1035 Hollins St.

15 FILED APR 15 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 13" 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3. 1921, to Apr. 12 1921, that I last saw him alive on Apr. 12. 1921, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Throat.
3 Months

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) --- yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 1 1921

Was there an autopsy? No.

What test confirmed diagnosis? Patterlogical

(Signed) Edward Woolahan, M. D.

, 19 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 16" 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52926

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S. Paca St. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Fields

(a) RESIDENCE. No. 802 S. Paca St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15" 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William H. Fields

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D. C.

12 MAIDEN NAME OF MOTHER Maria Forteney

13 BIRTHPLACE OF MOTHER (city or town) York
(State or country) Pa

14 Informant Charles A. Melvin
(Address) 809 Scott St.

15 Filed APR 15 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 13" 1931

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1921, to April 12, 1921, that I last saw her alive on April 12, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~Yes~~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mary A. Toay, M. D.

4/14. 1921 (Address) 429 E. Lombard ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Apr. 15" 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bal. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52927

CERTIFICATE OF DEATH.

120 D 52927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 W Lombard ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel R Bradburn

(a) RESIDENCE. NO. 1006 W Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella V Bradburn

6 DATE OF BIRTH (month, day, and year) June 13, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R R

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER John Bradburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C

12 MAIDEN NAME OF MOTHER Eliza Cammack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Ella Bradburn

(Address) 1006 W Lombard

15 Filed APR 15 1921 ROBERT J KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12th 1921

17 I HEREBY CERTIFY, That I attended deceased from aug 1 1919, to april 12 1921.

that I last saw him alive on April 12, 1921,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Walter A Cox, M. D.

(Address) 541 Fulton Ave 4/14/1921

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Apr 15th 1921

20 UNDERTAKER John J Gowan & Son

ADDRESS 901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52928

CERTIFICATE OF DEATH.

169

1-PLACE OF DEATH Pier No 1- Bost Pt 19 REGISTERED No. C.....

CITY OF BALTIMORE (No. Bernard ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard. F. Koerger.

(Residence in Baltimore: No. 326 S. Gilmor St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	White	Married

6-DATE OF BIRTH, Sept. 21-, 1875
(Month) (Day) (Year)

7-AGE, 45 yrs. 6 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electric Wilder
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Bernard Koerger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Rosa Lupman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Alice Koerger

(Address) 326 S. Gilmor St -

15- Filed APR 15 1921 ROBERT J. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning -

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs.....mos.....ds.

(Signed) Geo Clinton Slade M. D.
(Coroner)

4/14/21 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Apr. 16- 1921

20-UNDERTAKER John J. Cowan & Son ADDRESS 901 Hollins St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

F

D 52929

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52929

CERTIFICATE OF DEATH.

REGISTERED No. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Northeast Mc. Meechen (on the bridge) ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Hynson

(Residence in Baltimore: No. 913 Morris St. St.; 38 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, March 15, 1888
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): (General)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John H. Hynson

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Katie Gray

13-BIRTHPLACE OF MOTHER (State or Country), Baltc. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Hynson

(Address) 913 Morris St

15- Filed APR 15 1921 191 ROTHERT & KRAUTER Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage of left coronary artery (Duration) 1 day yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis degeneration (Duration) 1 day yrs. mos. ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

April 13, 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, April 15 1921

20-UNDERTAKER Samuel T. Hensley ADDRESS 518 W. Biddle St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52930 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 52930

30

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: W Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Louise Kilmore

(a) RESIDENCE. No. 2018 E. Broadway St.. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mulvin-Helper do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Thomas Kilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary A. Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant R. K. Hoddinott

(Address) 1732 N Fulton ave

15 Filed APR 15 1921 ROBERT A. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 1921

17

I HEREBY CERTIFY, That I attended deceased from 4/12, 1921, to 4/14, 1921, that I last saw h— alive on 4/14, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis ?

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Irwin C. Rodgers, M. D

4/17 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn cem	4/16 1921
20 UNDERTAKER	ADDRESS
Robert Brookerson	175 Calhoun

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 52931

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 Russell ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ann Russell

(a) RESIDENCE. No. 900 Russell ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Russell

6 DATE OF BIRTH (month, day, and year) Oct 30 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	71	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John McGarvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Sarah A Russell 900 Russell St.

15 Filed APR 15 1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/7/21, 19..., to 4/14/21, 19...

That I last saw h... alive on 4/14/21, 19...,

and that death occurred, on the date stated above, at 11-55 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Dorsey M. D.

(Address) 2309 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Apl 18 1921

20 UNDERTAKER Wm Carle ADDRESS 502 E Fayette

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D 52932

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST.: 13 WARD)

2-FULL NAME George W. Hoppman

(a) RESIDENCE. NO. 2371 Mc Culloh ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? 44 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 24 1876

7 AGE — Years: 45 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John R Jamison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Eliz. A Hoffa

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto Md

14 Informant (Address): Allie D Zollinhofer 2371 Mc Culloh St

15 Filed APR 15 1921 19 ROBERT P. BRUTE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to April 14, 1921, that I last saw him alive on April 14, 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis, Cholelithiosis
Local Peritonitis

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? At Residence

Did an operation precede death? Yes Date of 4/11/21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W E Tom Jamison M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 18 1921
20 UNDERTAKER	ADDRESS
Wm Cook	702 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52933

CERTIFICATE OF DEATH.

28 D 52933

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Hasko

(a) RESIDENCE. No. 825 St. Paul st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Hasko

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 67

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Thos. E. Gordon

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) D.C.

12 MAIDEN NAME OF MOTHER Alice B. Thompson

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D.C.

14 Informant Hospital Records

(Address) M.T.H.

15 APR 15 1921 ROBERT P. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1921, to April 14, 1921, that I last saw h... alive on April 13, 1921, and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum.

(Signed) J. J. Cigrey. M. D.

4-14-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 15 1921

20 UNDERTAKER Harry N Witzke — ADDRESS 1331 W Lombard st

CAUSE OF DEATH in plain terms. Abbreviations not to be used. ALL should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52934

CERTIFICATE OF DEATH.

92

D 52934

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 Elmwood Roland Park ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Glanville Rusk M.D.

(a) RESIDENCE. No. 110 Elmwood Rod Roland Park ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hilary Elizabeth Yeardley

6 DATE OF BIRTH (month, day, and year) Sept 1 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer) 154

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jacob Krebs Rusk

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine O. Carter

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C. (State or country)

14 Informant Alexander T. Rusk

(Address) 110 Elmwood Rd Roland Pk

15 APR 15 1921 ROBERT J. [illegible] Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14th 1921

17

I HEREBY CERTIFY, That I attended deceased from April 10th, 1921, to April 14th, 1921, that I last saw her alive on April 13th, 1921, and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (acute Lobar)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood culture (positive)

(Signed) Wm H. Dabney, M. D.

, 19 (Address) Ruxton. Baltimore Co. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 16 1921

20 UNDERTAKER — ADDRESS

Isaac B. Spence 1325 N. Caroline St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52935

CERTIFICATE OF DEATH.

126 D 52935

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital St.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Stockdale

(a) RESIDENCE. No. 1615 E. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Stockdal

6 DATE OF BIRTH (month, day, and year) Dec. 16. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Modeller

(b) General nature of industry, business, or estsblishment in which employed (or employer) Employee

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua M Stockdale

11 BIRTHPLACE OF FATHER (city or town) Unknown.

(State or country)

12 MAIDEN NAME OF MOTHER Adeline Mills

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Maryland

14 Informant Adeline Stockdale

(Address) 1615 E Biddle St

15 FILED APR 15 1921 ROBERT I. TRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1921

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1921, to April 13, 1921, that I last saw him alive on April 13, 1921, and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertrophied Senile Prostate

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-1-21

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bromwell, M. D.

4-13-1921 (Address) St Jos. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 16 1921

20 UNDERTAKER John B. Spence ADDRESS 1325 N Caroline St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 52936 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 52936

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 Lunsdeen ST.; 1 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Coll

(Residence in Baltimore: No. 205 Lunsdeen St.; 74 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, Col. Mulatto

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, ..., 1847
(Month) (Day) (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tobacco
(b) General nature of industry, business, or establishment in which employed (or employer): Do

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Coll

(Address) 313 Lemmon St

15-APR 15 1921 COUNTY [illegible]

Filed ....., 191.... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 12, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 10 1921, to April 12 1921, that I saw h[illegible] alive on 4 11 1921, and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows: Valvular Heart Disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Bright's Disease

(Duration) yrs. 6 mos. ds.

(Signed) A. Colbourn M. D.

4/13, 1921. (Address) 1800 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, April 16 1921

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52937

CERTIFICATE OF DEATH.

154

D 52937

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 N. Wolfe ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Burgan

(a) RESIDENCE. NO. 416 N. Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hester A. Burgan

6 DATE OF BIRTH (month, day, and year): Dec. 1, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigarmaker, retired

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm Burgan

11 BIRTHPLACE OF FATHER (city or town) (State or country): (Md

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Edward F. Burgan

(Address): 519 N. Washington

15 Filed APR 15 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 28, 1921, to Apr 12, 1921, that I last saw h[illegible] alive on Apr. 12, 1921, and that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows:

Old Age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter White M. D.

4/13 1921 (Address) 2800 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	April 15 1921
20 UNDERTAKER: Birkler & Birkler	ADDRESS 1739 Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52938

CERTIFICATE OF DEATH.

119

D 52938

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 215 S. Hurst (St.:) Brooklyn 25 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Granuaqu Edwards

(a) RESIDENCE. No. 215 S. Hurst St. Brooklyn Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Edwards

6 DATE OF BIRTH (month, day, and year): Unknown 1837

7 AGE: Years 84 | Months | Days | If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Q. A. Co. Md

PARENTS

10 NAME OF FATHER: John Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lavinia Lacy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Zachariah Edwards

(Address): 329 S. Second St.

15 Filed: APR 15 1921 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to Apr. 12, 1921, that I last saw him alive on Apr. 11, 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic.

(Signed) Thos. B. Hollis, M. D.

(Address) 1 Cedar St. C. B.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch	April 15 1921
20 UNDERTAKER	ADDRESS
John H. Sadler	242 N. Bell St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52939 D 52939

CERTIFICATE OF DEATH.

154

1-PLACE OF DEATH aged Home for Incurables REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2001 E Baltimore St.; X3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chone Klarunsky

(Residence in Baltimore: No. 219 S. Spring St St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1821 (Year)

7-AGE, 96 — — yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levis

(Address) 1411 E Balt St

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk Registrar.

APRT 5 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4-15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 11 1921, to April 14 1921, that I saw h in alive on April 14 1921, and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Samuel S. Hutchcomb M. D.

1921. (Address) 1395 W Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State 40 yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 219 S Spring St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, 4-15, 1921

20-UNDERTAKER Jack Levis — ADDRESS 1411 E Balt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52940

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D 52940

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Baker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Buckheimer

(a) RESIDENCE. No. 1616 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mathias Buckheimer

6 DATE OF BIRTH (month, day, and year) Feb 5th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Midwife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER —— Hanker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John G. Buckheimer
(Address)

15 Filed Robert P. Harris, Registrar

APR 15 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14th 21

17

I HEREBY CERTIFY, That I attended deceased from January, 19 19, to April 14th, 19 21, that I last saw h er alive on April 14th, 19 21, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fehling's Test

(Signed) John G. Organ, M. D.

, 19 (Address) 7 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	April 18 21
20 UNDERTAKER	ADDRESS
Daniel Easterly	Lemmon

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52941 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52941

D 52557 79 D 52557

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE Rosedale Collins Ave Pen Dis (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph L Allen

(a) RESIDENCE. No. Rosedale Collins Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occ Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie E Allen

6 DATE OF BIRTH (month, day, and year) Jan 8/1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plaster 057

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edmund R Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Ellie Perkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Fannie E Allen

(Address) Rosedale Collins Ave

15 Filed 1921 Robert P. Harris Registrar

Death Certificate Clerk

McDonald 1540 N Broadway

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1921, to April 1, 1921, that I last saw h.. alive on Mar. 31 1921, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 13 mos. — ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. 13 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical tests

(Signed) A W Macdonald, M. D.

April 1, 1921 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 19 21

20 UNDERTAKER William Oak ADDRESS 502 E Fulton

BECAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 52942

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2121 Orleans St ST.: 6th WARD)

2-FULL NAME Anna Bartsch

(a) RESIDENCE. NO. 2121 Orleans St ST., 6th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Bartsch

6 DATE OF BIRTH (month, day, and year) Nov 29 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Gocke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary M. Wachsblick

(Address) 2258 N Collington Ave

15 Filed APR 15 1921, 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1921

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1921, to April 15, 1921, that I last saw h[illegible] alive on April 14, 1921, and that death occurred, on the date stated above, at 1 ¼ m.

The CAUSE OF DEATH* was as follows:

Neoplasm Abdominis

(duration) ..... yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Jaundice & Pulmonary Oedema (duration) ..... yrs. ..... mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed) Adolph C. Eisenberg, M. D.

4/15 1921 (Address) 2201-03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 18 1921
20 UNDERTAKER	ADDRESS
Wm C. Miller	2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tumor of the abdomen not cancerous.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52943 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52943

CERTIFICATE OF DEATH. 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. St., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Schlag

(a) RESIDENCE. No. 1817 N. Payson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Charlotte Bowen Schlag

6 DATE OF BIRTH (month, day, and year) Aug 25 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent do

(b) General nature of industry, business, or establishment in which employed (or employer) dry-goods house

(c) Name of employer Kline & Marfit

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wilhelm Schlag

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Seubert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wilhelm Schlag (Address) 1817 N. Payson St

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

R 15 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1921

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1921, to April 15, 1921, that I last saw h[illegible] alive on April 15, 1921, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Appendicitis

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 4/11/21

Was there an autopsy? No

What test confirmed diagnosis? Pathology & Clinical

(Signed) Philibert Artigiani M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	April 18 1921
20 UNDERTAKER	ADDRESS 1944
Harry W. Ehlen	W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52944

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 52944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 N Lombard ST.: 4 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Lee Katzenberger Jr

(a) RESIDENCE. No. 632 N Lombard ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 27, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Robert Lee Katzenberger

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Lillie Rowe

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Father (Robert Lee Katzenberger)
(Address) 632 N Lombard St

15 Filed APR 15 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr 14, 1921, to Apr 15, 1921,

that I last saw h alive on Apr 14, 1921,

and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Intoxication, Convulsions (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James L Katzenberger, M. D.

4/15, 1921 (Address) 1729 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	April 16 1921
20 UNDERTAKER	ADDRESS
Wm J. Tickner & Sons	Balt. Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52945

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 52945

1-PLACE OF DEATH 2935 W Walbrook ave. 120

REGISTERED NO. C.....

CITY OF BALTIMORE (No. ..... ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah J Lehmen

(Residence in Baltimore: No. 2935 Walbrook ave. St. 70 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Aug. (Month) 28 (Day), 1850 (Year)

7-AGE: 70 yrs. 7 mos. 17 ds. | If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE (State or country): Balto. Md.

PARENTS

10-NAME OF FATHER: John Rhydes

11-BIRTHPLACE OF FATHER (State or country): England

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas J. Lehmen

(Address) 2935 Walbrook Ave

15

Filed ..... 191 Robert P. Harrison, REGISTRAR

APR 15 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 15 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5 1921, to Apl. 15 1921, that I saw her alive on Apl. 15 1921, and that death occurred, on the date stated above, at 2 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 10 yrs. ... mos. ... ds

Contributory (SECONDARY) Cause

(Duration) ... yrs. mos. 3 ds.

(Signed) Bernard Preston Muse M. D.

April 15 1921 (Address) 1037 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. | In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western | DATE OF BURIAL: April 18 1921

20-UNDERTAKER: Jer. W. Little | ADDRESS: 2700 Edmondson Ave

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52946

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 Gough ST.; V WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Edward B. Harrigan

(Residence in Baltimore: No. 1823 Gough St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, Feb. 7, 1904.
(Month) (Day) (Year)

7-AGE, 17 yrs. 2 mos. 7 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Apprentice Printer.
(b) General nature of industry, business, or establishment in which employed (or employer): 063

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Michael E. Harrigan

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Catherine Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Harrigan

(Address) 1823 Gough St

15-

Filed ....., 191.... Robert P. Harrison,
Registrar.

APR 16 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 14, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1921, to April 14 1921, that I saw him alive on April 14 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene L. Pennyno M. D.

April 15, 1921. (Address) 2314 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral cemetery	April 18, 1921.
20-UNDERTAKER M. Doyle	ADDRESS 156 Fawn St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52947

D 52947

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 648 Mulberry St.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Curry

(Residence in Baltimore: No. 648 Mulberry St.; 6 yrs., — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, ... (Month) 4 (Day) — (Year) 1893

7-AGE, 28 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Annapolis Md

PARENTS.

10-NAME OF FATHER, Frank Curry

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Gant

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Curry

(Address) 707 Otterbein St

15-

Filed ..... 191.. Registrar.

R 6 1921 Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) — 13 (Day) — 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6. 1921, to April 13 1921, that I saw h[illegible] alive on April 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Acute Nephritis

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) John C Hawes M. D.

4-14-21, 191.. (Address) 704 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Apr. 17, 1921.

20-UNDERTAKER John H. Trading — ADDRESS 142 Hull St

D 52948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52948

CERTIFICATE OF DEATH.

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 12 Jones Hospital ST.; WARD)

2-FULL NAME John Holy

(Residence in Baltimore: No. 112 Filbert St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) S.

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 17 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Shipwrecker
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Michael Holy

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Moran

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Holy

(Address) 112 Filbert St

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

APR 13 1921 Burial Permit Issued

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 14 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Tuberculosis Int Lung

Unk (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] (Coroner.) M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross — DATE OF BURIAL, ..., 19..21

20-UNDERTAKER Frank Enoch Son — ADDRESS 1906 Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52949

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 ✓ D 52949

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25-29 Emerson ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Beach

(a) RESIDENCE. NO. 25-29 Emerson ST. 11 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard Beach

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 71 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Charles Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Martha Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Herbert L Beach

(Address) 25-29 Emerson St

15 Filed Robert P. Harrison, Registrar

APR 6 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl 14 19 21

17 I HEREBY CERTIFY, That I attended deceased from April 11, 19 21, to April 14, 19 21, that I last saw her alive on April 14, 19 21, and that death occurred, on the date stated above, at 1030 p m.

The CAUSE OF DEATH* was as follows:

Paralysis

Stroke (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Richard [illegible] M.D.

19 (Address) 1211 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Apl 18 1921

20 UNDERTAKER: Chenoweth Son — ADDRESS: Chestnut Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109 D 52950

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 Clipper Road or ... WARD)

2-FULL NAME Estella M Crawford

(a) RESIDENCE. NO. 1340 Clipper Road WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. 6 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Sept 24 1920

7 AGE — Years: ... Months: 6 Days: ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): M D

PARENTS

10 NAME OF FATHER: Charles H Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Carrie Ennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Charles H Crawford 1340 Clipper Road

15 Filed ... Robert P. Harrison, Registrar

APR 6 1921

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1521

17

I HEREBY CERTIFY, That I attended deceased from April 14th, 1921, to April 14th 21.

That I last saw h[illegible] alive on April 14th 21.

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

... (duration) yrs. ... mos. 1½ ds.

CONTRIBUTORY (Secondary): Same as above

... (duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) B A Lucas, M. D.

April 16 1921 (Address) 1427 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	April 16 21

20 UNDERTAKER: Chenoweth & Son — ADDRESS: Chestnut ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52951 ✓ 50 D 52951

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 660 Pitcher ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Francis Jones'

(a) RESIDENCE. No. 660 Pitcher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 10 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zachariah Jones

6 DATE OF BIRTH (month, day, and year) May 30. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife. 37

(b) General nature of indostry, business, or establishment in which employed (or employer) Cooking - Washing

(c) Name of employer Self. Etc.

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER George W Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Zachariah Jones
(Address) 660 Pitcher

15 Filed APR 6 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1921

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1921, to April 14, 1921, that I last saw h Er alive on April 13, 1921, and that death occurred, on the date stated above, at 4.57 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pyorrhoea.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary. Physical

(Signed) Wm. H. Wright, M. D.

APR 4, 1921 (Address) 1209 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Apr. 18 1921
20 UNDERTAKER	ADDRESS
Theo. White	113 S. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Brown)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52952

D 52952

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 808 N Spring St. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Brown

(a) RESIDENCE. NO. 808 N. Spring ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lonette Brown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City Born

PARENTS

10 NAME OF FATHER John T. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) City.

12 MAIDEN NAME OF MOTHER Lillie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Lanette Brown

(Address) 808 N Spring St.

15 Filed 4/10/21 Robt P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14/21

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1919 to 4/14/21, that I last saw him alive on 4/14/21, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Paralysis.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 808 N. Spring St.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert H. Levy M.D.

4/15/21 (Address) 1207 E. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U.S. National Ct.	April 15 1921
20 UNDERTAKER	ADDRESS
A. L. Brown's Son	108 W. Monto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should have CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52953

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 610 Belnord Ave ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Lee

(a) RESIDENCE. NO. 610 Belnord Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 8 1897

7 AGE — Years: 23 — Months: 7 — Days: 7 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Spreader

(b) General nature of industry, business, or establishment in which employed (or employer): in Clothing Factory

(c) Name of employer: McCoubly

9 BIRTHPLACE (city or town) (State or country): Carroll Co md

PARENTS

10 NAME OF FATHER: Isa. Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co md

12 MAIDEN NAME OF MOTHER: Rosa M. Ebaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co md

14 Informant: Mrs Rosa M. Lee
(Address): 610 Belnord Ave

15 Filed ... 19... Robert P. Harrison, Registrar

APR 16 1921 Burial Permit ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15 1921

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to April 14, 1921, that I last saw h... alive on April 14, 1921, and that death occurred, on the date stated above, at 12 20 A. m.

The CAUSE OF DEATH* was as follows:

Pelvic Carcinoma

(duration) ... yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? ... Hospital

Did an operation precede death? Yes Date of Aug 15-20

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F F Reynolds, M. D.

(Address) 800 N Gallena Blk Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: April 18 1921

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 2173 Pac...

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and informant may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably originated in rectum.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Pikesville 3

M V. 6765

D 52954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Seven Apartments

CITY OF BALTIMORE: (No. Cathedral & Mount St.; 11 WARD)

REGISTERED No. 172

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Virginia Clarke

(a) RESIDENCE. No. Seven Apartments ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1858 Nov 22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	82	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Thompson City Pa
(State or country)

PARENTS

10 NAME OF FATHER Abraham Coleman

11 BIRTHPLACE OF FATHER (city or town) Chesapeake City
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Cundiff

13 BIRTHPLACE OF MOTHER (city or town) Chesapeake City
(State or country)

14 Informant Henry A. Clark

(Address) Seven Apts

15 Filed APR 16 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to April 15, 1924, that I last saw h[illegible] alive on April 10, 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture of Femur, Neck

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home - Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

April 16, 1924 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 18 1924
20 UNDERTAKER	ADDRESS
Henry H. Jenkins & Son	Oakland & Gold

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

In trying to get out of
floor fell & broke
her leg - Accident

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52955 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52955

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 N. North Av ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Stern

(a) RESIDENCE. No. 2226 N. North Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14/1874

7 AGE: Years 46 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Merchandise

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Moses Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertie Katz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Rosa Stern

(Address) 2226 N. North Av

15 Filed Robert P. Harrison, Registrar

APR 6 1921 Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14th 1921

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to April 14, 1921,

that I last saw him alive on April 14, 1921,

and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis larynx

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Florida?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacilli in sputum

(Signed) Charles P. Mortimer, M. D.

, 19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chesed Shalom — DATE OF BURIAL: 4/17 1921

20 UNDERTAKER: Wm Sondheim — ADDRESS: 1104 W Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 172 52956

OK H.K. Gorsuch Coroner-Md 251

1-PLACE OF DEATH University Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No..... ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Saunderson

(a) RESIDENCE. No..... Tolleburg Va. ST., ... WARD. Tolesburg Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tolsbury Va

PARENTS

10 NAME OF FATHER James Saunderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Flowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lizzie Tunnells

(Address) 1319 Prestman St

15 Filed APR 6 1921 Robert P. Harrison, Registrar

Deputy Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1921

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1921, to April 14, 1921, that I last saw h.im alive on April 14, 1921, and that death occurred, on the date stated above, at 3:50 a. m.

The CAUSE OF DEATH* was as follows:

Compound fracture skull
Brain abscess
Hernia Cerebri
(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 13, 1921

Was there an autopsy? Yes.

What test confirmed diagnosis? Aspiration & Ventricle

(Signed) Cyrus F. Harine, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL

Bendelets Northumberland Co 19

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST. APR 14 1921

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental Fell from
horse

(Frazzitta)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52957 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52957

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 136

CITY OF BALTIMORE: (No. Mercy Hosp. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rosa Frazzitta

(a) RESIDENCE. No. 1534 Sahara Terrace ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Angelo Frazzitta

6 DATE OF BIRTH (month, day, and year) June 24 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvadore Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Calimeta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Record
(Address)

15 Filed APR 16 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/9 1921 to 4/19 1921, that I last saw h- alive on 4/19 1921, and that death occurred, on the date stated above, at 2.40 a m.

The CAUSE OF DEATH* was as follows:

Contracted Pelvic Peri. & Capsy. Pus.
Caesarean Section

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Adynamic Ileus

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/9/21 Caesarean Section

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Laurin O. Ridgely, M. D.

(Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	(Apr 18 1921

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 E Fayette

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52958 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52958

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 184

CITY OF BALTIMORE (No. Found in the water, Woodall's Shipyard (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.

(Residence in Baltimore: No. Unknown. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, Do not know. (Month), 1 (Day), ... (Year)

7-AGE,	If LESS than 1 day,
about 1 hour. yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Do not know.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Police report.

(Address).....

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Blank.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Found March 30th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation.
String tied around the neck.
Homicide.
..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ....yrs....mos....ds.

(Signed) Otto M. Rosenhardt M. D.
(Coroner.)

April 11 1921 (Address) 1917 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
.....
Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, JOHNS HOPKINS HOSPITAL — DATE OF BURIAL, APR 16 1921, 19...

20-UNDERTAKER Commissioner Health. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52959

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lawther

(a) RESIDENCE. No. 1110 Riggs ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ~~Unknown~~ 14 years mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Presser

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Norfolk Virginia

PARENTS

10 NAME OF FATHER Peter Lawther

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER Emma Pue

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant: Hospital Records

(Address): M.T.H.

15 Filed Robert P. Harrison, Registrar

APR 16 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to April 14, 1921, that I last saw him alive on April 14, 1921, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) [signature], M. D.

4-14-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Berkley Va	Apr 16 1921
20 UNDERTAKER: Sam'l W. Chase Nor	ADDRESS: 400 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52960

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp. St.; 9 Ward) REGISTERED NO. ×120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Turner

(a) RESIDENCE. No. So. St. Md. St., Ward. Sharrows Point Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Turner

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
43				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Keyesville Va

PARENTS

10 NAME OF FATHER Jacob Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ella Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Pearl E. Williams

(Address) 1200 S. Patterson Phila Pa

15 Filed APR 16 1921, 19 Robert P. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to April 13, 1921

that I last saw her alive on April 13, 1921.

and that death occurred, on the date stated above, at 12 40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis C. Marine, M. D.

4/14/1921 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	Apr 17 1921
20 UNDERTAKER	ADDRESS
Sam'l W. Chase & Son	1400 Maker

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52961

28 D 52961

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3516 Roland Ave. ST.: 13 (WARD)

2-FULL NAME Olive L Latchford

(a) RESIDENCE. No. 3516 Roland Ave. ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert H. Latchford

6 DATE OF BIRTH (month, day, and year): Jan. 5- 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Blanche A. Krouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Albert H. Latchford 3516 Roland Ave

15 Filed APR 16 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to April 15, 1921, that I last saw h[illegible] alive on April 14 (9 P.M.) 1921, and that death occurred, on the date stated above, at 2 20 A m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary): (Same)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) R. B. Norment, M. D.

(Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: April 18 1921

20 UNDERTAKER: Horace Burgee Son — ADDRESS: 363 Stall[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Dr. Wm. A. B. Sellman.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52962

D 52962

CERTIFICATE OF DEATH.

REGISTERED No. C 87

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bedder Sellman Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann McComas

(Residence in Baltimore: No. 1620 Madison Ave St.; ..... yrs., 7 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	white	Single

6-DATE OF BIRTH, September 10, 1913.
(Month) (Day) (Year)

7-AGE, 7 yrs. 7 mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) At Home

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Donald McComas

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Ethel Estep

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Donald McComas

(Address) 1620 Madison Ave.

15-

APR 16 1921

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 14, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 11 1921, to April 14 1921, that I saw h.. alive on April 14 1921, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, broncho

(Duration) .... yrs. .... mos. 1 .... ds.

CONTRIBUTORY (Secondary) Congestion of Lungs

(Duration) .... yrs. .... mos. 2½ ds.

(Signed) W. A. B. Sellman M. D.

April 14, 1921. (Address) 5 E. Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State 4 yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? 1620 Madison Ave

Former or usual residence 1620 Madison Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	4-16-21

20-UNDERTAKER	ADDRESS
Chas. S. Evans & Son	118 N. Eutaw St

I. D. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52963

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2803 Overland Ave. ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Belz.

(a) RESIDENCE. No. 2803 Overland Ave. ST., WARD.

(Usual place of abode) Lifetime (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude R. Belz

6 DATE OF BIRTH (month, day, and year) July 16-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	9	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Peter Belz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Keil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gertrude R. Belz

(Address) 2803 Overland Ave.

15 Filed Robert P. Harrison, Registrar

PR 16 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 11, 1921, to April 14, 1921.

that I last saw h... alive on April 14, 1921.

and that death occurred, on the date stated above, at 6 40 p m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Phthisis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas J. Innes, M. D.

4/14 1921 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery,	4/18/21

20 UNDERTAKER Chas J. Evans & Son ADDRESS 118 W. Mt. Royal Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52964 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52964

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 13 Ward)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Lipsitz

(Residence in Baltimore: No. 2419 Woodbrook Ave. St.; ..... yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Apr. (Month) 15 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant (D)
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, David Lupsitz

11-BIRTHPLACE OF FATHER (State or Country) Madison Me.

12-MAIDEN NAME OF MOTHER Jannetta Reid

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Lupsitz

(Address) Woodbrook Md

15- APR 17 1921 Filed ..... 191.... ROBERT J. BAUER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 15 1921, to Apr 15 1921, that I saw him alive on Apr. 15, 1921, and that death occurred, on the date stated above, at 4 0 m.

The CAUSE OF DEATH* was as follows:

Respiratory obstruction, occasioned by blood in respiratory passages.

(Duration) ... yrs. ... mos. 30 min. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) A. K. Koontz M. D.

Apr. 15, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 30 min. ds. In the State Md. yrs. ... mos. 30 min. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew Cem

DATE OF BURIAL, April 17 1921

20-UNDERTAKER Jahrens & Co

ADDRESS 16 N Madison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

52965 D 52965

CERTIFICATE OF DEATH.

50 D 52965

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 Bolton ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny Fernheimer

(Residence in Baltimore: No. 2109 Bolton St.; ....yrs.,....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 15 (Day), 1861 (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Julius Isenford

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lisette Breslau

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis F. Fernheimer

(Address) 2109 Bolton St

15- Filed APR 17 1921, 191.... ROBERT F. LAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 22 1912, to April 15 1921, that I saw h[illegible] alive on April 14 1921, and that death occurred, on the date stated above, at 12 54 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Mediastinum

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulm. Oedema

(Duration) yrs. 1 mos. ds.

(Signed) Louis F. Hamburger M. D.

April 16 1921 (Address) 170 7 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Har Sinai Cem. DATE OF BURIAL, 4/17, 1921

20-UNDERTAKER J. H. Rees & Co. ADDRESS 16 N. Howard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 52966

1 PLACE OF DEATH

28 X150

D 52966

REGISTERED No. C .....

CITY OF BALTIMORE (No. Harman Hospital for Crippled Children St. Hill dec Ward) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charlotte Davis

(Residence in Baltimore: No. Davis Wharf Va St.; yrs. mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Single

6 DATE OF BIRTH: June 3, 1919 (Month) (Day) (Year)

7 AGE: 1 yrs. 10 mos. 18 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Davis' Wharf Va

PARENTS

10 NAME OF FATHER: Ford M. Davis

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Edna Wise,

13 BIRTHPLACE OF MOTHER (State or country): Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. E. Wise

(Address) 106 Brantley Ave, Balto.

15 Filed APR 17 1921 ROBERT I. CARTER Register of Wills REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 16th, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to April 16 1921, that I saw her alive on April 16, 1921, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Illness, following operation

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY): Hydrocephalus

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Tunstall Taylor M. D.

4/16/, 1921 (Address) 2000 Ed. ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. 2 ds.

Where was disease contracted, if not at place of death? Congenital

Former or usual residence: Davis Wharf Va

19 PLACE OF BURIAL OR REMOVAL: Starkville Va — DATE OF BURIAL: April 17, 1921

20 UNDERTAKER: Geo. W. Lisle — ADDRESS: 2704 Edmondson

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52967

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3509 Bonner Road ST.; 15 WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Digges Wills

(a) RESIDENCE. No. 3509 Bonner Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis H. Wills

6 DATE OF BIRTH (month, day, and year): May 20. 1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Charles Co. Maryland

PARENTS

10 NAME OF FATHER: John H. Digges

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Mary Clements

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Mary E. Wills
(Address) 3509 Bonner Rd

15 Filed APR 17 1921 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1921, to April 16, 1921, that I last saw h[illegible] alive on April 15, 1921, and that death occurred, on the date stated above, at 115 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. 1 Week

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Personal exam

(Signed) Francis F. Nicholas M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas. Charles Co Md	Apr 18 1921
20 UNDERTAKER: John O. Mitchell	ADDRESS: 1201 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52968

D 52968

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 908 S. First St. St.: 26 Ward)

2-FULL NAME Rose Lohman

(a) RESIDENCE. No. 908 S. First St St., 26 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Lohman

6 DATE OF BIRTH (month, day, and year) Aug. 17- 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Seitz

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Boehm

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant George E. Lohman (Address) 908 S. First St.

15 Filed APR 17 1921 ROBERT S. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/28/21, 19..., to 4/15/21, 19..., that I last saw h.. alive on 4/14/21, 19..., and that death occurred, on the date stated above, at 10.00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis with hypertension

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Intoxication

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. McGarrell M. D.

19 (Address) 633-S-3d

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	April 18th 1921
20 UNDERTAKER Tilly & Zitlau	ADDRESS 403 S Mo Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52969

CERTIFICATE OF DEATH.

28

D 52969

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Jones

(a) RESIDENCE. NO. 566 Wilson st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bootblack

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Albert Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fannie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed APR 17 1921 ROBERT F. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15, 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1921, to April 15, 1921, that I last saw him alive on April 15, 1921, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis.

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. S. Fahndrich, M. D.

4-15-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Apr-18 1921
20 UNDERTAKER	ADDRESS
Edw. Ruggold	1462 Carey st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52970

CERTIFICATE OF DEATH.

X 79 D 52970

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2022 Brunt ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sedonia Smith

(Residence in Baltimore: No. 2022 Brunt St.; ....yrs., 3 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb. (Month) 2 (Day) 1867 (Year)

7-AGE, 54 yrs. 2 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gareth H. Smith

(Address) 2022 Brunt St.

15- Filed APR 17 1921 ROBERT I KRAUTHOFF Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 13 1921, to April 14 1921, that I saw her alive on April 14 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) ~~~

(Duration) ....yrs. ....mos. ....ds.

(Signed) John D. Turner M. D.

April 18, 1921 (Address) 1301 Druid Park Drive

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Virginia

19-PLACE OF BURIAL OR REMOVAL. Lumbs Wharf North Thumberland Va.

DATE OF BURIAL. Apr. 17, 1921.

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 Carey St.

N.B.—Entire lack of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 52971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52971

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 Fayette St.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Gallaher

(Residence in Baltimore: No. 525 Fayette St.; ..... yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) 1860 (Day) 1 (Year)

7-AGE, ... yrs. 61 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Private

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Samuel Madden

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johnson J. Johnson

(Address) 1207 Eutaw St.

15- ROBERT J. CRAUTH

Filed APR 17 1921, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 14th, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15th 1921, to April 14th 1921, that I saw h.. alive on April 14th 1921, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Pneumonia)

Senile (Pneumonia)

(Duration) ..... yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Following Grippe

(Duration) ..... yrs. 1 mos. 3 ds.

(Signed) A. Lee Claw M. D.

4/16th, 1921 (Address) 922 Mad. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westminster Cemetery

DATE OF BURIAL, April 17, 1921.

20-UNDERTAKER Edward Ruggold

ADDRESS 1463 Carey St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52972

CERTIFICATE OF DEATH.

45

D 52972

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 Chauncey Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Berman

(Residence in Baltimore: No. 808 Chauncey Avenue St.; 28 yrs., 9 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... January ..... (Month) 6th (Day), 1892 (Year)

7-AGE, 28 yrs. 9 mos. 10 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Optician
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Isaac Berman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Fannie —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry M. Rosenthal

(Address) 2373 Callow Ave

15-

FILED APR 17 1921 1921 ..... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April ..... (Month) 16 ..... (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 10th 1920, to April 16th 1921, that I saw h was alive on April 16th 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of the pancreas

..... (Duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry M. Rosenthal M. D.

April 16, 1921. (Address) 2373 Callow Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, 4-17, 1921

20-UNDERTAKER Jack Levis — ADDRESS 1411 E Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52973

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52973

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1439 Laurens St St. 16 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stillborn baby Thor

(a) RESIDENCE. No. 1439 Laurens St St., ... Ward.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/16/21

7 AGE — Years — Months — Days / If LESS than 1 day, ... hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md

PARENTS

10 NAME OF FATHER Philip Thor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Rosenbloom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 E Balto St

15 Filed APR 17 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16 1921

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1921, to April 16, 1921, that I last saw him alive on April 16, 1921, and that death occurred, on the date stated above, at 8.15 a m.

The CAUSE OF DEATH* was as follows:

Lived 15 minutes after born. Cause of death prolonged labor.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Stillborn baby was born 8. a.m. April 16/21

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas W Burkhart M. D.

, 19 (Address) 1101 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 4/17/21

20 UNDERTAKER: Jack Lewis — ADDRESS: 1411 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS FORM IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52974

CERTIFICATE OF DEATH.

170 D 52974

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 Callington Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Heckler

(a) RESIDENCE. No. 1921 Callington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Max Milton Heckler.

6 DATE OF BIRTH (month, day, and year): Mar 20 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67 Years.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ——— Fld

(b) General nature of industry, business, or establishment in which employed (or employer): At Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm Renna.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Louis Heckler
(Address): 1921 Callington ave

15 Filed: APR 17 1921 ROBERT P. KRAUTH Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 16, 1921, that I last saw her alive on April 16, 1921, and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis Cerebritis

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

.....(duration) .....yrs. 3 mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John T Avery, M. D.

, 19 (Address) 1603 Bunday

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	Apr 19 1921
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E North ave

Dr Avery 1603 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 52975

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 52975

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Johnson

(Residence in Baltimore: No. 215 N. Franklin St.; 53 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH: Dec. 23, 1867
(Month) (Day) (Year)

7-AGE: 53 yrs. 3 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stage hand
(b) General nature of industry, business, or establishment in which employed (or employer): 680

9-BIRTHPLACE, (State or Country), Balto. Md,

PARENTS.

10-NAME OF FATHER, Chas. Johnson

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Emily J. Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lorenz Johnson,

(Address) Lee Hill, Md.

15-APR 17 1921 ROBERT F. KRAUTH

Filed....., 191.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 14, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull (base)

(Duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Accident

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

April 19, 1921 (Address) 2802 Edgewood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place ~~Md. Gen. Hosp.~~ In the
of death.....yrs.....mos.....2 ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?
215 W. Franklin St.,

Former or usual residence Same,

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Olivet	4/18, 1921.
20-UNDERTAKER William Cook	ADDRESS, 5026 York Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52976

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52976

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Davis

(a) RESIDENCE. NO. 2233 E Biddle ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Davis

6 DATE OF BIRTH (month, day, and year) July 25 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Repairman

(b) General nature of industry, business, or establishment in which employed (or employer) B and O RR.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Alice Terrill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Alice Walker

(Address) 500 Ensor St

15 Filed APR 17 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1921

17

I HEREBY CERTIFY, That I attended deceased from March 22 1921, to April 16 1921, that I last saw h.. alive on April 16 1921, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Peabody M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hamden	Apr 17/21 19
20 UNDERTAKER Wm Cook.	ADDRESS 502 E Monument ave.

BOARD OF HEALTH—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tuberculous

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 52977

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 Sterling ST. 5 WARD)

2-FULL NAME Mary Anderson

(a) RESIDENCE. NO. 635 Sterling ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	B	Married

5a If married, widowed, or divorced
(or) WIFE of Thomas H. Anderson

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... or ... min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hsw. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co. Md

PARENTS

10 NAME OF FATHER Henry Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thomas H Anderson
(Address) 635 sterling st

15 Filed APR 17 1921 ROBERT E. LAZENBY Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to apr 13, 1921, that I last saw h.er alive on apr 13, 1921, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

chronic Myocarditis

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) A. H. Hornstein, M. D.

4/14, 1921 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	April 17 1921

20 UNDERTAKER ... ADDRESS R E Trott 1405 McElderry St

N. B.—WHEN FILLED WITH UNDERSTANDING, THIS IS A PERMANENT RECORD, AND ANY ERROR OR OMISSION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D52978

HEALTH DEPARTMENT—CITY OF BALTIMORE

D52978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3706 Park Heights St. 15 WARD)

REGISTERED No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosaria Cicero

(a) RESIDENCE. No. 3706 Park Heights ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Vincent Cicero

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Zito

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Campbell (Prof)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Cicero
(Address) 1719 Hanover st

15 FILED APR 17 1921 ROBERT I. CRAVEN Registrar

Burial in Mt. Olivet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Apl 12, 1921, to Apl 16, 1921.

that I last saw her alive on Apl 16, 1921,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Trouble

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. L. Wentworth, M. D.

1924 (Address) 1211 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Apr 18 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52979

CERTIFICATE OF DEATH.

89 D 52979

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 W. Lexington ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie R. Washiell

(Residence in Baltimore: No. 1419 W. Lexington St. St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow.

6-DATE OF BIRTH, Jan. (Month) 8 (Day), 1843 (Year)

7-AGE, 78 yrs. 4 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Daniel Evans.

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Amanda Collins

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard T. Hammett.

(Address) 1419 W. Lexington

15- APR 17 1921 ROBERT J. KRAUTER
Filed, 191 Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 12 1921, to Apr 15 1921, that I saw h W alive on Apr 14 1921, and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Aorta Bronchitis & arteriosclerosis (Duration) yrs. mos. 4 ds.

(Signed) M Baumandkoval M. D.

Apr. 16, 1921. (Address) 626 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Apr. 18, 1921
20-UNDERTAKER George J Smith	ADDRESS 1000 Fayette W

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52980

64 ✓ D 52980

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Scott ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Mc Caffrey

(a) RESIDENCE. No. 1016 Scott ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mc Caffrey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Peter Mc Caffrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

11 Informant Mrs Mary Mc Caffrey

(Address) 1016 Scott St.

15 APR 18 1921 ROBERT E LEE OTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1921

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1921, to April 13, 1921, that I last saw him alive on April 13, 1921, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis + H.B. Rheumatism

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos Lord Dr Asst. M. D.

, 19 (Address) 600 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	4/18/21
20 UNDERTAKER	ADDRESS
John J Fahey & Son	1318 Light St

N. B.—PRINT PLAINLY WITH PEN AND INDELIBLE INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 32881 HEALTH DEPARTMENT—CITY OF BALTIMORE D 32881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Reid & Hillen Hoffman St.; 11 WARD) 175 005

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Ford

(Residence in Baltimore: No. 904 McCulloh St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, ... November ....., 1908
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
12 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Student
(b) General nature of industry, business, or establishment in which employed (or employer)..... Newsboy

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Frank Ford

11-BIRTHPLACE OF FATHER (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Emma Agie

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Ford

(Address) 904 W. McCulloh St.

15- Filed APR 18 1921 191.... ROBERT J. KRAUTER Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April 15 ....., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull, accidental
Run over by wagon
Instantaneous death (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... T. Hennessy ..... M. D.
(Coroner.)

April 17 1921 (Address) 2502 Edgewood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Scottsville Va — DATE OF BURIAL, April 17 1921

20-UNDERTAKER Hamme & Wright — ADDRESS 1364 N. Carey

D 52982 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52982

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 24175-00

CITY OF BALTIMORE (No. In front of 1443 Hull St. St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Zuelch.Jr.

(Residence in Baltimore: No. 1442 Hull St.

5 yrs., 8 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, July 17th. 1916. (Month) (Day) 1 (Year)

7-AGE, 5 yrs. 8 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Zuelch.Sr.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Daisy Rice.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daisy Zuelch.(mother)

(Address) 1442 Hull St.

15- APR 18 1921 Filed ....., 191... ROBERT I KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 14th. 1921. (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull and Internal Hemorrhage. Accidentally struck and run over by an Automobile.

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto Reinhardt M. D. (Coroner.)

Apl. 15., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem.	Apl. 16th. 1921.
20-UNDERTAKER	ADDRESS
Wm. J. Evans & Son	1428 S. Charles

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52983

CERTIFICATE OF DEATH.

91 D 52983

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 Mc Elderry ST.: 5 WARD)

2-FULL NAME Louise Hursey

(a) RESIDENCE. NO. 1219 Mc Elderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —— 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city

PARENTS

10 NAME OF FATHER Howard Hursey

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Trice

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

11 Informant. Ethel Hursey
(Address) 1219 Mc Elderry st

12 Filed APR 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1921

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1921, to April 15, 1921, that I last saw h alive on April 14, 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Fisher, M. D.

4/15/21 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	April 18 1921
20 UNDERTAKER Mrs D. G. Locke	ADDRESS 1302 Hillen

D 52984 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 52984

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lonzo Giles

(Residence in Baltimore: No. 613 N. Mulberry St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: ..... March ..... (Month) ..... 17 ..... (Day) ..... 1861 (Year)

7-AGE: 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): Department Hosp

9-BIRTHPLACE, (State or Country): born in Harford Co lived in Baltimore about 30 years

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. Giles

(Address) 613 N. Mulberry St.

15-APR 18 1921 ROBERT A. ELLIOTT

Filed ....., 191.... Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April ..... (Month) ..... 16 ..... (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (3 hrs)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) No history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hennessy M. D. (Coroner.)

April 17, 1921 (Address) 2807 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Md. Gen. Hosp. In the city of death ..... yrs. ..... mos. 22 ds. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 508 Park Ave.

Former or usual residence 613 N. Mulberry St.

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, April 19, 1921

20-UNDERTAKER Wm Robert A Elliott — ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D 52985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 52985

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 803 Mc Kim St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Cargo

(Residence in Baltimore: No. 803 McKim St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Boy

6-DATE OF BIRTH, April 19, 1919.
(Month) (Day) (Year)

7-AGE, 1 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Ernest-Cargo

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Estelle Chaney

13-BIRTHPLACE OF MOTHER (State or Country), born in Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Estelle Chaney

(Address) 803 McKim St

15-

Filed APR 18 1921, 191.

[illegible] Registrar.

Burial Permit [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 16, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

4-16., 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, April 18, 1921

20-UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52986

CERTIFICATE OF DEATH.

28

D 52986
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 535 N Exeter ST.: 5 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Price

(Residence in Baltimore: No. 535 N Exeter St. St.: 2yr. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 43 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer Odd

9-BIRTHPLACE, (State or Country) born in Baltimore City

PARENTS.

10-NAME OF FATHER, James Price

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Mary Fletcher

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Price

(Address) 535 Exeter St

15- APR 18 1921 Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) W C Elliott M. D.
(Coroner.)

4/15/21, 1921 (Address) 216 Emory

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury Cemetery	April 18, 1921
20-UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

Earling

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52987

CERTIFICATE OF DEATH.

1920 D 52987

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1253 Sargent ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara V Earling

(a) RESIDENCE. No. 1253 Sargent ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) April 17th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Zaukins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Cramm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Michael V Earling

(Address) 1213 Sargent St

Filed APR 18 1921 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 19 20, to Apr 17, 19 21, that I last saw h.. alive on April 16, 19 21, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hans Barge M. D.

Apr. 17, 19 21 (Address) 602 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	April 20 1921
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52988

CERTIFICATE OF DEATH.

8-09 D 52988

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 S Calhoun ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M Summers

(a) RESIDENCE. No. 302 S Calhoun ST., 19 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 8 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Norman E. Summers

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Clara Frock

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Norman E Summers
(Address) 302 S. Calhoun st

15 Filed APR 18 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/28/21, 19..., to 4/16/21, 19..., that I last saw h.. alive on 4/16/21, 19..., and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tb.

(duration) 2 yrs. 10 mos. ..... ds.

18 Where was disease contracted if not at place of death? 302 S Calhoun

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F. W. Wunsch, M. D.

4/16, 19 21 (Address) 1302 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 19 1921
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52989

CERTIFICATE OF DEATH.

D 52989

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1242 W. Lombard ST. 19 WARD)

2-FULL NAME Worthington L. Jones

(a) RESIDENCE. (Usual place of abode) No. 1242 W. Lombard ST., 19 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Feb 6 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Jones Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joshua Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ebelthayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Alice Jones

(Address) 1242 W. Lombard

15 Filed APR 18 1921 WORK. A. LEAUTEL Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/7/21, 19..., to 4/15, 1921, that I last saw h[illegible] alive on 4/14, 1921, and that death occurred, on the date stated above, at 7:40 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Regurg.

(duration) 3(?) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

April 15, 1921 (Address) 1302 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 19 1921

20 UNDERTAKER John J. Fields 1002 W. Lombard ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52990

CERTIFICATE OF DEATH.

40

D 52990

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 245 W. Preston ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Last~~ Nellie J White

(Residence in Baltimore: No. 245 W. Preston st St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Not Known, ... (Month) ..... (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
65 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dress Maker
(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home

9-BIRTHPLACE, (State or Country), Not Known

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Flint

(Address) 245 W. Preston

15- ROBERT J. KRAUSE

Filed APR 18 1921 19.... Robert J. Krause Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 17th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 8 1921, to April 17 1921, that I saw her alive on April 16 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion & Pain

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Chas. L. Benbert M. D.

April 17 1921 (Address) 1100 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Catholic Cemetery	April 18 1921.
20-UNDERTAKER	ADDRESS
W. M. Routen	2238 N Milton City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

5299T

CERTIFICATE OF DEATH.

28 D 52991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 East Lexington ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Brown

(a) RESIDENCE. No. 1018 East Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/6/73

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Samuel Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Sister. Mrs. Dixon

(Address) 1018 E. Lexington St

15 Filed APR 18 1921 19.... ROBERT N. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/21 19

17 I HEREBY CERTIFY, That I attended deceased from February 10 1921, to April 17, 1921, that I last saw h.. alive on April 4 t, 1921, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 119 Rear St

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Spec. Microscopic

(Signed) L. Woodward, M. D.

, 19 (Address) 6 North Front St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	4/20 19
20 UNDERTAKER	ADDRESS
Mullen Co	508 E Mt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 52992

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 3724 E Lanvale St.; 26 WARD)

2-FULL NAME Margaret E. Dollerdt

(a) RESIDENCE. No. 3724 E Lanvale WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 24 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward C Dollerdt

6 DATE OF BIRTH (month, day, and year) Aug 31, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	33	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Columbus Gitting

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret E. Kruse

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Edward C Dollerdt

(Address) 3724 E Lanvale St

15 Filed APR 18 1921 19 ROBERT A. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1920, to Apr 17, 1921.

that I last saw h[er] alive on Apr 17, 1921.

and that death occurred, on the date stated above, at 6 10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) W. E. Huemer, M. D.

(Address) 1301 N Pat Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 20 1921

20 UNDERTAKER ADDRESS

Wm Carlson & Rath

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52993

CERTIFICATE OF DEATH.

28 D 52993

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 East Lafayette ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Oliver Robinson

(a) RESIDENCE. No. 100 East Lafayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Robinson

6 DATE OF BIRTH (month, day, and year) July 18 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph E. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co. Md

12 MAIDEN NAME OF MOTHER Carrie Boone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Maryland

14 Informant Joseph E. Robinson

(Address) 100 E. Lafayette Ave

15 Filed APR 18 1921 ROBERT J. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 24, 1921, to Apr 15, 1921, that I last saw him alive on Apr 15, 1921, and that death occurred, on the date stated above, at 145 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Exam + Sputum Exam.

(Signed) Geo McLean, M. D.

, 19 (Address) 20 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 4/20 1921

20 UNDERTAKER: Williams Cook — ADDRESS: 507 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

McClain 20. E. Preston

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52994

CERTIFICATE OF DEATH.

79

D 52994

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 651 N. Paca ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Walker

(Residence in Baltimore: No. 651 Paca St.; 36 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Mar 20th, 1877
(Month) (Day) (Year)

7-AGE, 44 yrs. 0 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Walker

(Address) 651 N. Paca St

15- Filed APR 18 1921 ROBERT J. KRAUTH Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 15th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 11th 1921, to Apr 15th 1921, that I saw h[illegible] alive on Apr 14th 1921, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
of the Heart

(Duration) 1 yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) not known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harriet F. Brown M. D.

Apr 16th, 1921. (Address) 501 Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Apr. 18, 1921

20-UNDERTAKER John H. Soading

ADDRESS 142 W. Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

D 52995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D 52995

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 532 Laurens ST.; 14 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Smith

(Residence in Baltimore: No. 532 Laurens St.; 48 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, March 3, 1873
(Month) (Day) (Year)

7-AGE, 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Jones

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Grace Ann Curtis

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss M. Jones

(Address) 532 Laurens St.

15- APR 18 1921 Filed....., 191.... ROBERT P. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, and from the autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart disease
Probably fatty degeneration
(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history
(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

April 17 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, 4/18/21 19....

20-UNDERTAKER Sam W. Chase-son

ADDRESS 1400 Mosher st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec. 6-9-19—H. P. Co.—1000 Blks.

HAYNIE

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 52996

CERTIFICATE OF DEATH.

91 D 52996

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1401 Mosher st. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fortune Haynie

(a) RESIDENCE. No. 1401 Mosher ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Sing'l

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 14th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Haynie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Northumberland Va

12 MAIDEN NAME OF MOTHER Ella Crockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Northumberland Va

14 Informant Ella Haynie
(Address) 1401 Mosher st

15 Filed APR 18 1921 ROBERT J. LAMPERT Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 10th 1921, to April 17th 1921, that I last saw h[illegible] alive on April 16th 1921, and that death occurred, on the date stated above, at 2.00 [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Leo. F. [illegible] M. D.

Apr 20, 1921 (Address) 2315 N. Dearborn Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Gen	Apr 18 1921
20 UNDERTAKER	ADDRESS
Sam'l W. Chase & Son	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 52997 HEALTH DEPARTMENT—CITY OF BALTIMORE D 52997

CERTIFICATE OF DEATH.

92-104

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Green Sts ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Witte

(a) RESIDENCE. No. 4th Ave. & 19th St. City ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of: Myrtle Witte

6 DATE OF BIRTH (month, day, and year): 1882-May 12

7 AGE — Years: 38 Months: 11 Days: 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Millwright

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Aug. Witte

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Augusta Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Myrtle Witte
(Address) 4th Ave + 19th St. (Canton)

15 Filed APR 18 1921 ROLLA F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): apr. 14 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-3, 1921, to 4-14, 1921, that I last saw him alive on 4-14, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Perforation of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? YES Date of 4-3-21

Was there an autopsy? no.

What test confirmed diagnosis? Operation

(Signed) J. M. Hundley, Jr. M. D.

, 19 (Address) University Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: April 18 1921

20 UNDERTAKER: Zickler & Zickler — ADDRESS: 1739 E. Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 52998

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S. Robinson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Hirschman

(a) RESIDENCE. NO. 410 S. Robinson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John C. Hirschman

6 DATE OF BIRTH (month, day, and year) Sept. 30. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John M. Shaner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. Roberts

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant John C. Hirschman (Address) 410 S. Robinson St.

15 Date APR 18 1921 ROBERT I. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1921, to Apr 16, 1921, that I last saw h. alive on apr 16, 1921, and that death occurred, on the date stated above, at 12.05 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. Reifschneider M. D.

4/17 19 (Address) 340 E East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartza	April 19 1921
20 UNDERTAKER Zurkler & Zurkler	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 52999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 52999

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 N. Washington ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma D. Clemens

(a) RESIDENCE. NO. 1523 N. Washington ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John Clemens

6 DATE OF BIRTH (month, day, and year): July 15, 1846

7 AGE — Years: 74 — Months: 9 — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas L. Hardesty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mary L. Donnelly

(Address) 1523 N. Washington

15 Filed APR 18 1921 ROBERT J. KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1921

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1921, to April 17, 1921, that I last saw her alive on April 17, 1921, and that death occurred, on the date stated above, at 9.40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 1 mos. 3½ ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 3½ ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

What there an autopsy? No

What test confirmed diagnosis?

(Signed) A. W. Macdonald, M. D.

April 17, 1921 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: April 20 1921

20 UNDERTAKER: Zurhorst & Zirkler — ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53000

151 D 53000

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 7 WARD)

2-FULL NAME Mary Jannette Kernan

(a) RESIDENCE. No. 505 E. Chase ST., 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) Apr. 15, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1 da. 5 hr.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Philip Kernan

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Annie Rodway

13 BIRTHPLACE OF MOTHER (city or town) Cardiff
(State or country) England.

14 Informant Thos. L. Gehring
(Address) 23 S. Eutaw

15 FILED APR 18 1921 ROBERT I. KRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1921, to Apr. 17, 1921, that I last saw her alive on Apr. 17, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Thos. L. Gehring M. D.

, 19 (Address) 23 S. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	April 18 1921

20 UNDERTAKER N. C. Wiedefeld ADDRESS 914 Greenmount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53001

CERTIFICATE OF DEATH.

151 ✓ D 53001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 17 WARD)

2-FULL NAME Miss Mildred Kernan

(a) RESIDENCE. NO. 1505 E. Chase ST., 8 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 15, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1d 14h 30m	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Philip Kernan

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Bridget Kenny

13 BIRTHPLACE OF MOTHER (city or town) Cardiff
(State or country) England

14 Informant Mrs. Philip Kernan
(Address) 23 E. Preston

15 Filed APR 18 1921 ROBERT P. BRAUER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1921, to Apr. 17, 1921, that I last saw h[illegible] alive on Apr. 17, 1921, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary) Premature birth (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Autopsy

(Signed) Thos. F. Galvin M. D.

, 19 (Address) 23 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	April 18 1921

20 UNDERTAKER H. C. Windfeld & Co ADDRESS 914 Gremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Lockley.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53002

CERTIFICATE OF DEATH.

1821 D 53002

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Lockley

(Residence in Baltimore. No. 1729 Orleans St.) 5 St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Don't Know, 11
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Lewis Lockley

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Iris Graham

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eudora Keys

(Address) 1729 Orleans St

15-

Filed APR 8 1921, 191. ROBERT F. KRAUTH Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy ~~or inquiry~~) thereon and from the evidence obtained by said (Inquest, autopsy ~~or inquiry~~) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in abdomen; Coronary Thrombus Perforated Duodenal Ulcer

(Duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Shot by Thomas Edwards

(Duration) yrs. mos. ds.

(Signed) H. R. Gr... M. D.
(Coroner.)

4-18, 1921. (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Virginia

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 4-12, 1921

20-UNDERTAKER Jesse T. Baker & Co.

ADDRESS 1300 Pennsylvania Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53003

CERTIFICATE OF DEATH.

28

D 53003

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 Lafayette Ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Snowden

(Residence in Baltimore: No. 113 Lafayette Ave ST.; 15 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) 8 (Day) 93 (Year)

7-AGE, 27 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Elevator Operator
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Snowden

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elenor Shelton

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Snowden

(Address) 111 N Pulaski St

15- APR 18 1921 ROBERT I. KRAUTH

Filed....., 191..... Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 16th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 19th 1921, to April 16th 1921, that I saw h[illegible] alive on April 14th 1921, and that death occurred, on the date stated above at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

..... Pulmonary Tuberculosis

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

April 16, 1921 (Address) 924 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, April 19, 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Penna Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 53004

HEALTH DEPARTMENT—CITY OF BALTIMORE

115 D 53004

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Wagon at St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eldridge Bates

(Residence in Baltimore: No. 1002 Wagon at St.; 16 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1875 (Year)

7-AGE, 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Bates sister

(Address) 1002 Wagon st.

15- ROBERT J. KRAUTER

Filed APR 18 1921 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from about Feb. 14 1921, to April 15 1921, that I saw him alive on April 14 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertrophy of Liver

(Duration) ..... yrs. ?? mos. ..... ds.

(Signed) J. E. Chesnutt M. D.

April 15, 1921 (Address) 222 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	April 17, 1921.
20-UNDERTAKER Edward Easton	ADDRESS 916 Eutaw st

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53005

CERTIFICATE OF DEATH.

150 D 53005

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Curtis Ave. Curtis Bay ST.; 25 WARD)

2-FULL NAME Vernon Lee Carrigan

(a) RESIDENCE. NO. 1511 Curtis Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) March 21/20.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry B. Carrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Berkley Co. W. Va.

12 MAIDEN NAME OF MOTHER Ethel May Lockard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Shepherdstown W. Va.

14 Informant Harry B. Carrigan
(Address) 1511 Curtis Ave.

15 Filed APR 18 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15/1921

17 I HEREBY CERTIFY, That I attended deceased from April. 10, 1921, to April. 15, 1921, that I last saw h.. alive on April. 14, 1921, and that death occurred, on the date stated above, at 12- m.

The CAUSE OF DEATH* was as follows:

Congenital malformation of heart.

(duration) 1 yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Pneumonia in Summer 1920

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. T. Davis, M. D.

April 15, 1921 (Address) 211 Church St. Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	April 18 1921
20 UNDERTAKER	ADDRESS
John F. Denny.	715 Light

Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53006

REGISTERED NO. 130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View. St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Staylor

(a) RESIDENCE. NO. 864 N. Monroe St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 61B

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed APR 18 1921 ROBERT I. KRAUS Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1921

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1920, to April 15, 1921, that I last saw him alive on April 15, 1921, and that death occurred, on the date stated above, at 12:05 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis
(Cerebral thrombosis)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) ½ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V. B. Herman, M. D.

4/15/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	4/19/21 19
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Hanford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53007

CERTIFICATE OF DEATH.

D 53007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 N. Hoyer St.; 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Brn. Kelly

(Residence in Baltimore: No. 1906 N Hoyer St St.; yrs., 1 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 23, 1921. (Month) (Day) (Year)

7-AGE, — yrs. 1 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Balt.

PARENTS.

10-NAME OF FATHER, Wilder Kelly

11-BIRTHPLACE OF FATHER (State or Country), Balt.

12-MAIDEN NAME OF MOTHER Bessie Knight

13-BIRTHPLACE OF MOTHER (State or Country), Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bessie Kelly.

(Address) 1906 N. Hoyer st

15- Filed APR 18 1921 ROBERT I. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 16 1921, to April 18 1921, that I saw her alive on April 18 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Bernstein M. D.

4-18-21 (Address) 1531 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore County — DATE OF BURIAL, April 19 1921

20-UNDERTAKER George J. Rutt — ADDRESS 1735 Hayford Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53008

CERTIFICATE OF DEATH.

D 53008

40

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3110 Montebello ave ST.: 9 WARD)

2-FULL NAME Sophia R Crate

(a) RESIDENCE. No. 3110 Montebello ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Henry Crate

6 DATE OF BIRTH (month, day, and year) May 28th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Casper Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Norman G Crate (Address) 3110 Montebello ave

15 Filed APR 18 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APRIL 16 1921

17 I HEREBY CERTIFY, That I attended deceased from JAN 10 1920, to APR 6 1921,

that I last saw her alive on APR 6 1921,

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Stomach? 1 week

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis Fusion Conflagrans

(duration) 5 yrs. 7 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Decker M. D.

4/16 1921 (Address) 928-E-North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 19th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cancer of Stomach

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53009

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 E Eager ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie E. Pistel

(a) RESIDENCE. NO. 1602 Barnes ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Pistel

6 DATE OF BIRTH (month, day, and year) April 5th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Napoleon Boss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Pistel
(Address) 1602 Barnes st

15 Filed APR 18 1921 ROBERT I. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 3 1921, to April 17 1921, that I last saw h a alive on April 16 1921, and that death occurred, on the date stated above, at 2.30a. m.

The CAUSE OF DEATH* was as follows:

Acute Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter W White M. D.

4/17, 1921 (Address) 2800 St Paul st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 19th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53010

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St Vincent Inf Asylum ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Brown

(a) RESIDENCE. No. St Vincent Asy ST. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 19 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Mabel Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant E. W. Matthews
(Address) St. Vincent Infant Asylum

15 Filed APR 18 1921 ROBERT J. KRAUS Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1921, to April 14, 1921, that I last saw h[illegible] alive on April 14, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

.....(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Heuter, M. D.

Apr 15, 1921 (Address) 1604 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Southern Cem	April 18 1921
20 UNDERTAKER	ADDRESS
Martin Hurley & Son	627 South

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

37 D 53011

D 53011

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Ho pital, Bay View ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Dent

(a) RESIDENCE. No. 427 W. Biddle St, ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington,
(State or country) D.C.

PARENTS

10 NAME OF FATHER James Dent

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucille Clark

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed APR 18 1921 [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1921, to April 16, 1921, that I last saw her alive on April 15, 1921, and that death occurred, on the date stated above, at 8:00 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage into Psoas muscles (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) F. A. Holden, M. D.

4/16/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	Apr 18 1921
20 UNDERTAKER	ADDRESS
Sam'l H. Grace & Son	1700 Mad[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53012

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 53012

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 N. Central ave ST.: 9 WARD)

2-FULL NAME Rachel Todd

(a) RESIDENCE. No. 1314 N. Central ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Maryland

PARENTS

10 NAME OF FATHER James H. Todd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF Mary Elizabeth Crabb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carrol Co Md

14 Informant Geo. Todd

(Address) 1314 N. Central ave

15 Filed APR 18 1921 ROBERT E. LEWIS Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 17, 1921, to April 17, 1921, that I last saw her alive on April 16, 1921, and that death occurred, on the date stated above, at 3-15 A. m.

The CAUSE OF DEATH* was as follows:

Fracture of Femur

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert Carnapp. M. D.

4-17 1921 (Address) 1216 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 19 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidentally fell
on her wound

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53013

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital St. 1979-091 Ward)

REGISTERED NO. D 53013

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Emily Raines

(a) RESIDENCE. No. 224 South Carey St. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) Lancaster, Co. Va

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lancaster Co. Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Unknown

14 Informant Chas T. Jenkins
(Address) 1309 N Edison ave

15 Filed APR 18 1921 ROGER J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1921

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1921, to April 17, 1921, that I last saw her alive on April 16th, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Bronchial)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo E. H. Hardy, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 19 1921

20 UNDERTAKER ADDRESS

Chas. G. Black 742 W. North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Kesicki

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53014

D 53014

CERTIFICATE OF DEATH.

REGISTERED No. C 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040 Fountain ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kesicky

(Residence in Baltimore: No. 2040 Fountain St.; 1 yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) child

6-DATE OF BIRTH, Sept. 20, 1919. (Month) (Day) (Year)

7-AGE, 1 yrs. 6 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wladyslaus Kesicki

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Josephine Kumada

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wladyslaus Kesicki

(Address) 2040 Fountain St.

15- APR 18 1921 Filed....., 191.... ROBERT I. CRAWFORD Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 17 1921, to April 18 1921, that I saw him alive on April 18 1921, and that death occurred, on the date stated above, at 8 1/2 a. m.

The CAUSE OF DEATH* was as follows:

True Croup

(Diphtheritic)

(Duration) ....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) John H. Kelberger M. D.

April 18, 1921 (Address) 1709 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, April 18, 1921

20-UNDERTAKER John M. Weber — ADDRESS 1803 Bank St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53015

CERTIFICATE OF DEATH.

43 D 53015

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2727 Fenwick Av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecelia A. Hensing

(Residence in Baltimore: No. 2727 Fenwick Av St.; 66 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	White	Widow

6-DATE OF BIRTH, Oct 27, 1855.
(Month) (Day) (Year)

7-AGE, 66 yrs. 5 mos. 24 ds. | If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... do.

9-BIRTHPLACE, (State or Country) Balto, Md. U.S.A.

PARENTS.

10-NAME OF FATHER, Joseph Hallings

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ann E Barrett

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. Higgins

(Address) 2724 Fenwick ave

15- APR 18 1921 ROBERT J. KRAUTER

Filed ....., 191.... Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 16, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1920, to Apr 16 1921, that I saw h-- alive on Apr 17 1921, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma of Mediastinum (Posterior Middle)

about 4

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Medullary Carcinoma both (Pathological Exam. made)

Breasts (Duration) 1 yrs. 6 mos. ..... ds.

(Signed) Thos E. Geraghty M. D.

Apr. 16, 1921 (Address) 203 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery

DATE OF BURIAL, 4/19, 1921

20-UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53016

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Sharp ST., 23 WARD) 29

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susanna Rauderer

(Residence in Baltimore: No. 1015 E Sharp St St. Live yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov. (Month) 2nd (Day) 1840 (Year)

7-AGE, 80 yrs. 6 mos. 14 ds. | If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Rauderer

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md

12-MAIDEN NAME OF MOTHER Barbara Cook

13-BIRTHPLACE OF MOTHER (State or Country). Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances B. Hossfeld

(Address) 1015 Sharp St.

15- Robert P. Harrison,

Filed APR 18 1921, 191.....

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 16 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb. 19th 1921, to April 15 1921, that I saw her alive on April 15 1921, and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease Heart Do not know

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Carrick M. D.

April 18 1921 (Address) 412 N. Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cem | DATE OF BURIAL, April 19, 1921.

20-UNDERTAKER P. Leonard Son | ADDRESS, 237 Lanvale St.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Wiesman)

D 53017

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53017

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1718 N. Broadway St.; 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline J. Wiesman

(a) RESIDENCE. No. 1718 N. Broadway St.; Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of minn

6 DATE OF BIRTH (month, day, and year) March 1 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home mkr

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co
(State or country) md.

PARENTS

10 NAME OF FATHER Charles Kalbaugh

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country) md

12 MAIDEN NAME OF MOTHER Lucie Patterson

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) md

14 Informant J. Wiesman
(Address) 1718 N Broadway

15 Filed Robert P. Harrison, 19
Registrar
Burial Permit Clerk.

APR 18 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to April 17, 1921, that I last saw her alive on April 17, 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 5 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T Avery, M. D.

, 19 (Address) 1603 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Apl 19 1921
20 UNDERTAKER	ADDRESS
Roth & Johnson Inc	1424 Bway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53018

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 53018

CERTIFICATE OF DEATH

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1769 Carswell ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeanette Clark

(Residence in Baltimore: No. 1769 Carswell St St.; 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F

4-COLOR OR RACE W

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH Dec 31 1856 (Month) (Day) (Year)

7-AGE 65 yrs. 3 mos. 16 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Edinburgh Scotland

PARENTS

10-NAME OF FATHER George Clark

11-BIRTHPLACE OF FATHER (State or country) Scotland

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or country) Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. A. Williams

(Address) 1769 Carswell

15- Robert F. Harrison, Burial Permit Clerk REGISTRAR

APR 18 1921

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May, 1920, to, April 17 1921, that I saw her alive on April 16 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis with organic Heart disease

(Duration) 3 yrs. mos. ds.

Contributory (SECONDARY) Nephritis

(Duration) yrs. 2 mos. ds.

(Signed) Fritz S Klinger M. D.

April 18 1921. [Address] 2700 Harford Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Chippawa, Ont. Canada

DATE OF BURIAL 4/18/21, 191

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave.

U.S.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in giving items of information. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53019

CERTIFICATE OF DEATH.

D 53019

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarett Conciglia

(a) RESIDENCE. No. 729 N. Milton Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 8-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Claudini Conciglia.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Stabilay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Lucie Conciglia

(Address) 729 Milton Ave

15 Filed ....., 19 Robert P. Harrison, Registrar

PR[illegible] 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) april 17 1921

17 I HEREBY CERTIFY, That I attended deceased from april 12 1921, to april 17, 1921, that I last saw h[illegible] alive on april 17, 1921, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Diphtheria carrier

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? cultures.

(Signed) B. McGowan M. D.

4/18/1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent's Cemetery

DATE OF BURIAL April 18 1921

20 UNDERTAKER Mrs C. Miller

ADDRESS 2334 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53020

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 240 S. Wolfe St. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Dorsey

(a) RESIDENCE. NO. 240 S. Wolfe St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER William O'Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Catherine Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Anna Rettew
(Address) 240 S. Wolfe St.

15 Filed 19 Robert P. Harrison, Registrar

APR 18 1921 Record Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1920, to April 16, 1921, that I last saw her alive on April 15, 1921, and that death occurred, on the date stated above, at 12:15 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) Leo. Keller M. D.

April 17 1921 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	April 19 1921
20 UNDERTAKER Lilly & Zeller	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Francis W. Brown)

D 53021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St.: 172 WARD)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis W Brown

(Residence in Baltimore: No. Sykesville Md St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., (Month) 1 (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country). Sykesville Carroll Co Md

PARENTS.

10-NAME OF FATHER, Benj Brown

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER L. Podd

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B F Brown

(Address) Sykesville Md

15-

Died ....., 191.....

Registrar.

Robert P. Harrison,

Burial Permit Clerk.

APR 18 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Fell from Coal Pile at Sykesville

(Duration) ....yrs. mos. 3 ds.

(Signed) W. K. Franklin M. D. (Coroner.)

4-18, 1921. (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. 2 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Sykesville Md

19-PLACE OF BURIAL OR REMOVAL, Sykesville Md — DATE OF BURIAL, April 20, 1921

20-UNDERTAKER Wm R Weer — ADDRESS Sykesville Md

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

A.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53022

CERTIFICATE OF DEATH.

109 D 53022

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2357 Eutaw Place ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny. Metzger

(a) RESIDENCE. NO. 2357 Eutaw Place ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Metzger

6 DATE OF BIRTH (month, day, and year) Feby 12th 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Abraham Hecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Hetty Gutman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas D Mansfield
(Address) 2357 Eutaw Place

15 Filed , 19 Robert P. Harrison, Registrar

APR 19 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 12 , 1921, to April 16th , 1921, that I last saw h.. alive on April 16th , 1921, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction, (Woman Cyst?)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Michael A Abrams, M. D.

, 19 (Address) 2360 Entaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balt Hebrew	April 19th 1921
20 UNDERTAKER	ADDRESS
David Sondheim	1111 W. Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53023

CERTIFICATE OF DEATH.

64 D 53023

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 Chauncey Av ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Stirbl

(a) RESIDENCE. No. 817 Chauncey Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (Write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Mendel Stirbl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosalie Gumpf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs C Stirbl
(Address) 817 Chauncey Av

15 Filed APR 18 1921

Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1921

17 I HEREBY CERTIFY, That I attended deceased from April 14 1921, to April 17 1921, that I last saw her alive on April 17 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Ulcer Stom
Acute Cardiac Dilatation (duration) yrs. 3 mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Heart tones

(Signed) J. J. Shipman, M. D.

4/17 1921 (Address) 1920 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Adath Shalom	Apl 19 1921
20 UNDERTAKER	**ADDRESS**
Wm Sondheim	1182 W. Mt Royal

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53024

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53024

CERTIFICATE OF DEATH.

29

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N Paca ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aaron Lee

(Residence in Baltimore: No. 523 N Paca St.; 32 yrs., 8 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 27 (Day), 1889 (Year)

7-AGE, 32 yrs. 8 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)..... 56

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, W H Lee

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Green

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Mary Clements

(Address)..... 1334 Druid

15-

Filed ....., 191.....

Registrar.

APR 18 1921

Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH April (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 31 1921, to Apr 16 1921, that I saw h in alive on Apr 14 1921, and that death occurred, on the date stated above, at 930 m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia Lobaris

(Duration)..... yrs. ..... mos. 4 ds.

CONTRIBUTORY.....
(Secondary)

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) Adam E Burton M. D.

Apr 17 1921, (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, April 19 1921

20-UNDERTAKER Thompson & Eccleston — ADDRESS 114 N Howard St

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Stohen)

D 53025 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53025

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 407 S Eden St ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget G. Stohen.

(a) RESIDENCE. NO. 407 S Eden St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Stohen

6 DATE OF BIRTH (month, day, and year) Jan 27 1851.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None.

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Thomas Rochford.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Rochford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Florence Poleskamp (Address) 224 E Church St

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

APR 18 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-18 19 21

17 I HEREBY CERTIFY, That I attended deceased from Apl 1, 19 21, to Apl 18, 19 21,

that I last saw h— alive on Apl 17, 19 21,

and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Chron Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Path

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J Wheelan, M. D.

(Address) # 2 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	April 20 1921.
20 UNDERTAKER Wendell & Upperman	ADDRESS 7 E Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53026 D 53026

CERTIFICATE OF DEATH.

28

D 53026

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 S. Stricker ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Deems

(a) RESIDENCE. No. 313 S. Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec. 25th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pattern Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer United Railway Electric Co Baltimore Md

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George W Deems

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary A. Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

11 Informant Charles E. Deems
(Address) 231 S Calhoun st

12 Date APR 19 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 1920, to April 16 1921, that I last saw him alive on April 14 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E. E. Burton, M. D.

4-17 1921 (Address) 301 E. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	April 19th 1921
20 UNDERTAKER	ADDRESS
HOBERT BROOKS & SON	Calhoun & Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 53027

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 McElderry ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hursey

(a) RESIDENCE. No. 1229 McElderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city

PARENTS

10 NAME OF FATHER Howard Hursey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto city

12 MAIDEN NAME OF MOTHER Ethel Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant (Address) Howard Hursey 1219 McElderry St

15 Filed ... 19 ... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1921

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1921, to April 17, 1921, that I last saw him alive on April 17, 1921, and that death occurred, on the date stated above, at 9:30 p m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? NW

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher, M. D.

4-18 1921 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	April 19 1921

20 UNDERTAKER Wm J. G. Locks ADDRESS 1302 Jefferson

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53028

CERTIFICATE OF DEATH.

45 D 53028

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Fred. Schmitt

(a) RESIDENCE. NO. Fourteen Holy Martyrs WARD Church

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Unmarried (S)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Priest

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Rev. Bede Hornsch

(Address) Fourteen

15 Filed ....., 19 .....

APR 19 1921 BOARD OF HEALTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17 19 21

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 19 21, to Apr 17, 19 21

that I last saw him alive on " 7, 19 21,

and that death occurred, on the date stated above, at 12:50 m.

The CAUSE OF DEATH* was as follows:

1. Carcinoma of larynx

2. Carcinoma glands of neck.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion. (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-17-21.

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic.

(Signed) Dr. Geo. A Stewart, M. D.

, 19 (Address) St. Agnes Hosp (Pres St B).

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery Beatty, Pa. Westmoreland Co.	4/20/21
20 UNDERTAKER	ADDRESS
Knell & Son	172 W Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Christian

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53029

CERTIFICATE OF DEATH.

4 119 D 53029

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 779 Sarah Ann st ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florinda Christian

(Residence in Baltimore: No. 779 Sarah Ann St.; 36 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dont Know (Month) , 1 (Day) 1884 (Year)

7-AGE, 36 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Loyd Reed

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ellen Wise

13-BIRTHPLACE OF MOTHER (State or Country), Da

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Loyde Reed

(Address) 1502 W Mosher st

15-

Filed APR 19 1921 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) W K Gorsuch M. D.
(Coroner.)

4-18-, 1921. (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mont auburn — DATE OF BURIAL, April 19, 1921.

20-UNDERTAKER John H Owens — ADDRESS 638 Dolphin st

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 53030

D 53030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1343 Division St ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Adams

(a) RESIDENCE. No. 1343 Division ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Mar 4 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew R. Adams.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bertha Adams (Address) 1343 Division St

15 Filed APR 19 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1921

17 I HEREBY CERTIFY, That I attended deceased from March 5 1921, to April 16, 1921, that I last saw him alive on April 15, 1921, and that death occurred, on the date stated above, at 2.50 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Asthma & Dropsy.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Asthma & Dropsy

(duration) yrs. 1 mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hugh Kennard M. D.

4.17.1924 Address 1708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Allum Cemtry — DATE OF BURIAL April 19 1921

20 UNDERTAKER R. S. Parham — ADDRESS 649 W. Lex. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53031

CERTIFICATE OF DEATH.

64 D 53031

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 616 W Baltimore ST.; 4 WARD)

2-FULL NAME Charles Wilmot Wiley

(a) RESIDENCE. NO. 616 W. Baltimore St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk 609

(b) General nature of industry, business, or establishment in which employed (or employer) — none

(c) Name of employer — none

9 BIRTHPLACE (city or town) (State or country) Fork Baltimore

PARENTS

10 NAME OF FATHER William Wiley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fork Baltimore

12 MAIDEN NAME OF MOTHER Catherine D. Kellum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fork Baltimore

14 Informant William H. Kellum
(Address) 1012 E Lexington av

15 Filed ....., 19..... Registrar

APR 19 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1921

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1921, to April 18, 1921, that I last saw him alive on April 17-4, 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of x

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) V. Van Williams, M. D.

, 19 (Address) 601 Carrollton av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Apr 20 1921
20 UNDERTAKER	ADDRESS 1000
Geo J Smith	W. Fayette st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-13 H. P. Co.—1000 Bks.

D 53032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53032

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Nelson Gross

(a) RESIDENCE. NO. Somerville N. J. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George F. Gross

6 DATE OF BIRTH (month, day, and year) Dec 3-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER Henry H. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Narcissa Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky.

14 Informant (Address) Johns Hopkins Hospital Baltimore

15 Filed APR 19 1921 BOARD OF HEALTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1921

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1921, to April 18, 1921, that I last saw her alive on April 18, 1921, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic goitre

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Operative shock.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? Yes Date of April 16, 21

Was there an autopsy? No.

What test confirmed diagnosis? Pathological exam. of gland removed.

(Signed) Harry H. Wetherill, M. D.

(Address) Johns Hopkins Hosp. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Atlanta Ga	April 19 1921
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 N. Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(D) 53033

CERTIFICATE OF DEATH.

1 68 00 D 53033

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1907 Druid Hill Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William S. Galley

(Residence in Baltimore: No. 1907 Druid Hill Ave St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1847 (Year)

7-AGE, 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... retired (Steward)
(b) General nature of industry, business, or establishment in which employed (or employer) 80

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Levin Galley

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER McBunn

13-BIRTHPLACE OF MOTHER (State or Country) Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Burdis Wearn

(Address) 1907 Druid Hill Ave

15-APR 19 1921 REGISTRAR

Filed ....., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held na inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

I accidental asphyxiation by illuminating gas.

probably 1/2 hr. (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. T. Hennessy M. D. (Coroner.)

April 18 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, April 19 1921

20-UNDERTAKER John H. Toadvine — ADDRESS 142 W Lib St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Remarks: Accidentally burned gas on a sulf- burning gas light.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Jane Brice

D 53034

D 53034

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 N Mount ST.: 16 WARD)

2-FULL NAME Jane Brice

(a) RESIDENCE. No. 615 N Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 29-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Warren Brice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Carrie Brice (Address) 615 N Mount St.

15 Filed APR 19 1921 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18/21

17 I HEREBY CERTIFY, That I attended deceased from 1/29, 1921, to Apr 18, 1921, that I last saw her alive on April 17, 1921, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 2 mos. 17 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? / Date of

Was there an autopsy? /

What test confirmed diagnosis? /

(Signed) Walter F Dorsey, M. D.

4/18, 1921 (Address) 3405 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Apr 19, 1921
20 UNDERTAKER James & Toulson	ADDRESS 1214 W Franklin St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53035

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 125 N Pearl st ST. 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or Institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martina W. Wolf

(Residence in Baltimore: No. 125 N Pearl st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., (Month) — (Day) 1 (Year)

7-AGE, ...yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nom; CAD
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Peter Wolf

11-BIRTHPLACE OF FATHER (State or Country), Md. Ill

12-MAIDEN NAME OF MOTHER Eva Shipley

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva Wolfe

(Address) 125 N Pearl St

15- APR 19 1921

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...4.... (Month) ....15.... (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy or~~ inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis
Diagnosed at University Hospital

..... (Duration) ...1... yrs. ....mos. ....ds.

CONTRIBUTORY — (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ...W. K. Gorsuch.....M. D. (Coroner.)

4-19..., 1921. (Address) 117 W. Saratoga...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, April 15, 1921

20-UNDERTAKER Barry H Witzke

ADDRESS 1531 W Lombard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH LEAD PENCIL OR PEN AND INK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53036

CERTIFICATE OF DEATH.

D 53036

45

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 E. Federal ST.; 8 WARD)

2-FULL NAME Henry C. Buettner

(a) RESIDENCE. NO. 2201 E. Federal ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Katherine A. Buettner

6 DATE OF BIRTH (month, day, and year) Sept 23/91

7 AGE — Years: 29 — Months: 6 — Days: 23 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Leonard Buettner

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Leonard Buettner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Leonard Buettner
(Address) 2201 E Federal St.

15 Filed ..... 19 ..... Registrar

APR 19 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Apr 16, 1920, that I last saw h[illegible]ive on Apr. 13, 1920, and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma
of neck. 9
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Meningitis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert H. Levy, M. D.

4/18/1921 (Address) 1202 E. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk.

DATE OF BURIAL: Apr 19 1921

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53037

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sharey Ave near Harford & St.: Hamilton 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. J. Mitchell

(a) RESIDENCE. No. Sharey Ave. Hamilton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marian E. Mitchell

6 DATE OF BIRTH (month, day, and year) Jan 16 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Produce Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thos. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Marian E. Mitchell
(Address) Hamilton

15 Filed APR 19 1921 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1914 to April 16 1921, that I last saw him alive on April 15 1921, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatas Nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. LeRoy Wright, M. D.

, 19 (Address) 19 Aiken Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Apr 19 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53038

CERTIFICATE OF DEATH.

64 D 53038

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N Fulton Ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Andrew Mueller

(a) RESIDENCE. No. 215 N Fulton Ave ST., 6th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Anna E. Mueller

6 DATE OF BIRTH (month, day, and year): Jan 1 1857

7 AGE: Years 64 | Months 3 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Theodore R. Mueller

(Address): 215 N. Fulton Ave.

15 Filed APR 19 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1920, to April 17, 1921, that I last saw him alive on April 17, 1921, and that death occurred, on the date stated above, at 10 6m P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward [illegible] M. D.

4/18, 1921 (Address) 413 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Apr 20 1921

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Aliceanna

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53039 — 146 D 53039

1-PLACE OF DEATH St. Joseph Hospital.

CITY OF BALTIMORE: (NO. 1803 N Regester St. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Seeberger

(a) RESIDENCE. NO. 1803 N. Regester ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/12/1909

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
12	2	6	

8 OCCUPATION OF DECEASED None - Child.

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Seeberger

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Barbara Dehler

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Joseph Seeberger
(Address) 1803 N. Regester St.

15 Filed APR 19 1921 ROBERT J. BRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1921, to April 18, 1921, that I last saw him alive on April 18, 1921, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Septicaemia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute suppurative Mastoiditis (Bilateral)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/9/21 4/11/21

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J. Eschenmann, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 21 1921
20 UNDERTAKER	ADDRESS
Seeberger - F. Rusch	1735 Harford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 53040

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 53040

113

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Reilly

(a) RESIDENCE. No. 431 E. Eager St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Ella Reilly

6 DATE OF BIRTH (month, day, and year) Mch 10-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	0	0	0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) New York N.Y.

PARENTS

10 NAME OF FATHER Joseph A Reilly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of Mt Hope Retreat

(Address) Baltimore Md

15 Filed APR 27 1921 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1921

17

I HEREBY CERTIFY, That I attended deceased from June 30 1919, to Apr 26 1921, that I last saw him alive on Apr 26 1921, and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

abt (duration) 2 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Chronic Mania

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Apr 26 1921

20 UNDERTAKER Wenckel Dippell & Co ADDRESS 3731 Fr

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement should state OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

94 D 53041

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1147 W Cross ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Nugent

(a) RESIDENCE. No. 1147 W Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura A. Nugent

6 DATE OF BIRTH (month, day, and year) March 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine helper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

031

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Nugent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McCart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr Clarence Nugent
(Address) 1147 W Cross St

15 Filed APR 19 1921 ROBERT I. KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1921

I HEREBY CERTIFY, That I attended deceased from April 14 1921 to April 16 1921, that I last saw him alive on April 16 1921, and that death occurred, on the date stated above, at 4.45 m.

The CAUSE OF DEATH was as follows:

Edema of Lungs

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J. Lowe M. D.

(Address) 1125 W Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 20 1921
20 UNDERTAKER	ADDRESS
John J. Lowe & Son	907 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Corbin

D 53042 HEALTH DEPARTMENT—CITY OF BALTIMORE

1921

CERTIFICATE OF DEATH.

D 53042

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1326 N Mount ST.; 15 WARD)

2-FULL NAME Elizabeth Corbin

(a) RESIDENCE. NO. 1326 N Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Willis Corbin

6 DATE OF BIRTH (month, day, and year) May 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Randolph Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amy Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Minnie Corbin
(Address) 1326 N Mount St

15 Filed APR 19 1921 ROBERT I. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to Apr 17, 1921, that I last saw h[illegible] alive on Apr 17, 1921, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis with remission

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute renal

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Tests

(Signed) Edw Shorb, M. D.

, 19 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon	April 21 1921
20 UNDERTAKER	ADDRESS
Clarence E. Wright	1304 W Cary

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Parenchymatous Nephritis

Dec. Uraemia

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53043

CERTIFICATE OF DEATH.

91-145 D 53043

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Boon

(a) RESIDENCE. No. 15½ Rosslach St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of.

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Bill Boon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant New City Hosp. Records.
(Address)

15 Filed APR 19 1921 ROBERT J. BRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr. 9, 1921, to Apr. 5, 1921, that I last saw h/M alive on April 14, 1921 and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Elephantiasis of Penis & Scrotum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho - Pneum - Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Apr. 14, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Holden, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	4/19 1921
20 UNDERTAKER	ADDRESS
Myers Bros & Hooper	406 W. Conway St

N. B.—WRITE PLAINLY, WITH UNFADING INK—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53044

CERTIFICATE OF DEATH

D 53044

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Essex ST.: 1 st. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY NOWAK,

(a) RESIDENCE. No. 2203 Essex ST., 1 st. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Nowak,

6 DATE OF BIRTH (month, day, and year) October 4-1893,

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.,

PARENTS

10 NAME OF FATHER John Zubrowski,

11 BIRTHPLACE OF FATHER (city or town) Gosdowo, (State or country) Posen, Poland,

12 MAIDEN NAME OF MOTHER Leokadia Kowalewska,

13 BIRTHPLACE OF MOTHER (city or town) Posen, (State or country) Poland.

14 Informant William Nowak, (Husband) (Address) 2203 Esser Street

15 Filed APR 19 1921 ROBERT J. ARATIER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17- 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 15 1921 to April 17 1921, that I last saw h[illegible] alive on April 17 1921, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Sepsis following Miscarriage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William J. Rysono M. D.

4/18/21, 19 (Address) 501 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.,	April 20 1921
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

PHYSICIANS should state EXACTLY. Exact statement of OCCUPA- should be properly classified. certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53045

CERTIFICATE OF DEATH.

152

D 53045

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3512 Park Dale Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hornie

(a) RESIDENCE. No. 3512 Park Dale Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel John Hornie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Mae Horning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Samuel John Hornie

(Address) 3512 Park Dale Ave

15 Filed APR 19 1921 ROBERT J. KLAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1921, to April 19, 1921, that I last saw h[illegible] alive on April 18th, 1921, and that death occurred, on the date stated above, at 7.00 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) H. A. Lillich, M. D.

4/19 1921 Address) 1N. 27 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leister Cemetery Lapsed to	April 20 21

20 UNDERTAKER Chenoweth & Son ADDRESS Chestnut

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 53046

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 824 E. Fort Ave. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Chamberlain.

(Residence in Baltimore: No. 824 E. Fort Ave.

19 ---------

St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, March 11th 1860, 1
(Month) (Day) (Year)

7-AGE, 61 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Portsmouth, Va.

PARENTS.

10-NAME OF FATHER, Nathaniel Hyslop.

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Matilda. ---------

13-BIRTHPLACE OF MOTHER (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Getzler (daughter)

(Address) 824 E. Fort Ave.

15- Filed APR 19 1921, 191... ROBERT J. BRUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 17th 1921, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

April 16, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Portsmouth Va. DATE OF BURIAL, 4/20, 1921

20-UNDERTAKER Margaret G. Flynn ADDRESS 1422 Eighth St.

D 53047

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

152 D 53047

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 901 University Parkway Rld. Pk ST.: 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME – Baby Kruger

(Residence in Baltimore: No. same as above St.: yrs. mos. 1 ds.) (8½ hrs)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: ~~Female~~

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED WIDOWED OR DIVORCED~~ (Write the word): Single

6-DATE OF BIRTH: April (Month) 17th (Day), 1921 (Year)

7-AGE: ..... yrs. ..... mos. 1 ds. If LESS than 1 day, 8½ hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): ~~Md~~

9-BIRTHPLACE (State or country): Balto City. Md

PARENTS

10-NAME OF FATHER: Jas. P. Kruger

11-BIRTHPLACE OF FATHER (State or country): Balto. City Md.

12-MAIDEN NAME OF MOTHER: Mildred Dahl

13-BIRTHPLACE OF MOTHER (State or country): Balto. City. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas P Kruger

(Address) 20 University Parkway Md

15-APR 19 1921 Filed ..... 19..

ROBERT J. KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April 17th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4-17th, 1921, to 4-17th 1921, that I saw her alive on 4-17th, 1921, and that death occurred, on the date stated above, at abt 9.40 P.m.

The CAUSE OF DEATH* was as follows:

Most probably Hemorrhage of Spinal Cord

(Duration) ... yrs. ... mos. 8½ hrs.

Contributory (SECONDARY) Sharp flexion of head in Sentences delirium unattended

(Duration) ... yrs. ... mos. ... ds.

(Signed) Edenham R. Clarke M. D.

April 15th, 1921 (Address) Roland Park - Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mount Carmel — DATE OF BURIAL: April 20, 1921

20-UNDERTAKER: Wm. Thos. S. Dirk — ADDRESS: 1855 E. Oaut St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK ... THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53048 CERTIFICATE OF DEATH.

151 D 53048
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 S. Hanover ST.; 7V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Premature) Williams

(a) RESIDENCE. No. 426 S. Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) apr 16-1921

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or 15 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) Columbus
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Lillie Walker

13 BIRTHPLACE OF MOTHER (city or town) Hartsville
(State or country) S. Carolina

14 Informant John W Williams
(Address) 426 S Hanover

15 Filed APR 19 1921 ROBERT I CRAWFORD Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr, 17 1921

17 I HEREBY CERTIFY, That I attended deceased from apr, 16, 1921, to apr, 17, 1921, that I last saw him alive on apr, 16, 1921, and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth
(6½ mo. pregnancy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Doris Townsend, M. D.

4/17 1921 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	APR 18 1921

20 UNDERTAKER	ADDRESS
Commissioner Health,	

Per Wm. T. WOODALL

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53049

CERTIFICATE OF DEATH.

151 D 53049

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Haynie

(a) RESIDENCE. No. 1051 W. Fayette ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? ~ yrs ~ mos. ~ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) April 18, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or 40 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Carlie H. Haynie

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bessie Barrett.

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Virginia

14 Informant Mother (Bessie Haynie (Address) 1051 W Fayette Street JOHNS HOPKINS HOSPITAL

15 Filed APR 19 1921 ROBERT I. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1921

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1921, to April 18, 1921, that I last saw her alive on April 18, 1921, and that death occurred, on the date stated above, at 4:25 p.m.

The CAUSE OF DEATH* was as follows:

PREMATURITY

(22 WEEKS)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) PLACENTA PRAEVIA.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? NO Date of ~

Was there an autopsy? NO.

What test confirmed diagnosis? NONE.

(Signed) J. Morris Reese, M. D.

APR 18. 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL APR 19 1921

20 UNDERTAKER ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' attention is called to the fact that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

147404 D 53050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irma Dotter

(a) RESIDENCE. No. 3223 E. Fairmount st. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 21-1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1 5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edwin Dotter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hazel Pugh.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital Records.

15 Filed APR 21 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18-1921

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to April 18, 1921, that I last saw her alive on April 18, 1921, and that death occurred, on the date stated above, at 7:25 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis (purulent)
Etiology not known.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

4, 19 21 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chase Md.	April 20 1921
20 UNDERTAKER	ADDRESS
H. Sander & Son	1710 Fleet St.

B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53051

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53051

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Valentine Salkauskas

(a) RESIDENCE. No. 215 Presidents St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Vincent Salkauskas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Mrs. Salkauskas (Address) 1526 Pierce St

15 Filed APR 19 1921 19 Robert P. Harrison, Registrar

Burial Permit Blank.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1921

17

I HEREBY CERTIFY, That I attended deceased from 3/3, 19 21, to 4/18, 19 21, that I last saw h alive on 4/18, 19 21, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis Indetermined

(duration) yrs. mos. 2/ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis A. Rigby, M. D

4/18 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 21 1921
20 UNDERTAKER	ADDRESS
John Gobiunas	1525 S. Pierce St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53052 ✓ 150 D 53052

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 E. Lombard ST. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gerard John Dunk

(Residence in Baltimore: No. 1824 E. Lombard St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
M	White	Single

6-DATE OF BIRTH, April 17, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John C. Dunk

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Mary A. Faulstich

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C. Dunk

(Address) 1924 E. Lombard St

15-

Filed ....., 191.. Robert P. Harrison
Registrar.

APR 19 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 17 1921, to April 19 1921, that I saw him alive on April 16 1921, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Arthur C. Heaver M. D.

4/17, 1921 (Address) 2600 Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	April 20, 1921

20-UNDERTAKER	ADDRESS
John Herring & Co	2008 Orleans

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53053

64 D 53053

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 S. Linwood Ave ST.; 1 WARD)

2-FULL NAME Reinhold Hentz

(a) RESIDENCE. No. 1007 S. Linwood Ave ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Screw Hauler

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer Baltimore City Car Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Raymond Frank

(Address) 3447 Hudson St

15 Filed Apr 19, 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1921

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to April 18, 1921, that I last saw h alive on April 18, 1921, and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tilson, M. D

4/19, 1921 (Address) 315 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St German Cem	April 21 1921
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2046 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS' mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

APR 19 1921

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53054 28 D 53054

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 Guilford ave. ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Bolton

(a) RESIDENCE. No. 4769 Locust Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lyr. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Thomas L Bolton

6 DATE OF BIRTH (month, day, and year) Jan 13 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John Lauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Cath. Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Margaret Lauer
(Address) 2029 Guilford Ave

15 Filed APR 19 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/21

17 I HEREBY CERTIFY, That I attended deceased from Aug 1- 19 19 Apr 17, 19 21, to ..... 19 ....., that I last saw her alive on Apr 16 19 21, and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows: Phthisis Pulmonalis

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Bacteria.

(Signed) G. C. Hadley, M. D.

19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Apr 20 1921
20 UNDERTAKER Margaret D. Flynn	ADDRESS 14 S Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS' NAMES should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53055

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53055

CERTIFICATE OF DEATH.

X167

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Brown

(Residence in Baltimore: No. Sparrows Point, Md. St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	Unknown

6-DATE OF BIRTH, ... Unknown, 1 .....
(Month) (Day) (Year)

7-AGE, about 35 yrs, ...yrs. ....mos. ....ds.	If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer. Odd
(b) General nature of industry, business, or establishment in which employed (or employer)..... Bethlehem Steel Co.

9-BIRTHPLACE, (State or Country), N. Carolina

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Hoffman

(Address) Sparrows Point, Md.

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.
~~Burial Permit Clerk.~~

APR 19 1921

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April 15 ....., 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquiry .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... me .....
(Inquest, autopsy or inquiry.)
..... found that said deceased came to ..... his ..... death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Second degree burns of body & face.

(Duration) ....yrs. ....mos. 2 ....ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis

(Duration) ....yrs. ....mos. / ....ds.

(Signed) D. J. Hennessy M. D.
(Coroner.)

April 19 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Md. Gen. Hosp. in the of death ....yrs. ....mos. 2 ....ds. State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Sparrows Point Md.

Former or usual residence ..... Same .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Usbury Evergreen Cemetery	Apl 20 1921
20-UNDERTAKER John F. Denny	ADDRESS 715 Light St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53056

CERTIFICATE OF DEATH.

92 D 53056

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1608 E. Madison (St.) 7 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Curtis

(a) RESIDENCE. No. 1608 E. Madison St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fenal	Colored	My Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Curtis

6 DATE OF BIRTH (month, day, and year) Oct 24 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Raleigh N. C.

PARENTS

10 NAME OF FATHER Thomas Bostic

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raleigh N. C.

12 MAIDEN NAME OF MOTHER Edith Gipson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Raleigh N. C.

14 Informant (Address) George Curtis 1608 E. Madison St.

15 Filed APR 20 1921 19 ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19/ 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/7/ 1921, to 4/19/ 1921, that I last saw her alive on 4/19/ 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. R. Hawkins, M. D.

4/19/1921 (Address) 1216 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Raleigh North C	April 21 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53057

CERTIFICATE OF DEATH.

151

D 53057

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 N. Spring St.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Stewart

(Residence in Baltimore: No. 1819 N. Spring St.; 56 yrs.,.. mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	Single

6-DATE OF BIRTH, 4 (Month) 3 (Day), 1921 (Year)

7-AGE, ..yrs. 15 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Born in Baltimore Md

PARENTS.

10-NAME OF FATHER, Alexander Stewart

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Hattie Dayton

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander Stewart

(Address) 1819 N. Spring Ave.

15- ROBERT E EBAUGH

Filed..... 191..... Registrar.

APR 20 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 18 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 3 1921, to Apr 17 1921, that I saw h— alive on Apr 16 1921, and that death occurred, on the date stated above, at 5-0 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth, cause
Fracturing birth canal, embryo
Blood of Uterine gestation
(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. Gaines Stewart M. D.

Apr. 18, 1921 (Address) 1534 Druid Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion Cem	April 19..., 1921
20-UNDERTAKER Jas R A Elliott	ADDRESS 1725 Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

147084 D 53058

D 53058

CERTIFICATE OF DEATH.

REGISTERED NO. 679

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Stewart.

(a) RESIDENCE. No. 4197 N. Bond St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ~~6~~ mos. ~~10~~ ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Stewart (wife)

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. D&W

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lou in Eston Shore Md live in City 10 years Md.

PARENTS

10 NAME OF FATHER Lyford Bedford (Step-father)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Stewart D.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital Records.

15 Filed APR 20 1921 19 ROBERT I. LAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1921, to April 18, 1921, that I last saw h.im alive on April 18, 1921, and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Arteriosclerosis & Insufficiency
Mitral " & "
Lip wound
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Subacute bacterial endocarditis
Lip wound
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & pathological

(Signed) Edward C. Davidson M. D.

4-18, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cem

DATE OF BURIAL April 19 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53059 — D 53059

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital - 78 REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Bessie Sachs

(a) RESIDENCE. No. 1612 E. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 9 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5, 1902 -

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Benjamin Sachs -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia -

12 MAIDEN NAME OF MOTHER Yetta Goldman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records
(Address)

15 Filed APR 20 1921, 19 ROBERT F. [illegible]
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to April 19, 1921, that I last saw h[illegible] alive on April 19, 1921, and that death occurred, on the date stated above, at 8.58 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis
Septicaemia (Streptococcus viridans?)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) Geo. C. W. Hardy, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Mt. Carmel	4-19 1921
20 UNDERTAKER	ADDRESS
Jack Lewis,	1411 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53060 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53060

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 762 Wasche ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Holmes

(a) RESIDENCE. NO. 762 Wasche ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Holmes

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm. Holmes Jr
(Address) 762 Wasche St

15 Filed APR 21 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to April 18, 1921, that I last saw h... alive on April 17, 1921, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. Norwood, M. D.

19 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	April 21 19 21
20 UNDERTAKER	ADDRESS
S. L. Brown & Son	1018 W. Mount

N. B.—WRITE PLAINLY WITH UNFADING INK—PERMANENT RECORDS. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53061

CERTIFICATE OF DEATH.

D 53061

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Royal apt ST.: 11 WARD)

2-FULL NAME Lillie Taylor White

(a) RESIDENCE. NO. Mt Royal apt Calvert / Mt Royal ST., WARD

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Charles R. White

6 DATE OF BIRTH (month, day, and year) 12-13-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Henry J. Taylor

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Eliza Winchester

13 BIRTHPLACE OF MOTHER (city or town) Boston (State or country) mass

14 Informant Mrs. C. White (Address) Mt Royal apt

15 Filed APR 20 1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1921, to April 19, 1921, that I last saw h.e alive on April 19, 1921, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Asthma-Bronchial

Myocarditis.

(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Joseph William Metzky M. D.

, 19 (Address) 2327 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	4-21-1921

20 UNDERTAKER Henry J. Jenkins & Son ADDRESS McCulloh & Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 Emergency Hosp

D 53062

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. W B & A. Station or on way ST.: 64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara A. Rieve

(Residence ~~in Baltimore~~: No. Odenton Md. few hours St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Jan. (Month) 23 (Day), 1864 (Year)

7-AGE, 56 yrs. 2 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Andrew Snyder

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Margaret Bauer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jennie Murray.

(Address) Odenton Md.

15-

Filed APR 20 1921 191.... ROBERT J. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Colitis

Duration (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Cushing M. D. (Coroner.)

Apr. 20, 1921 (Address) 1037 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Odenton Md.

19-PLACE OF BURIAL OR REMOVAL, Holy Cross a a Co

DATE OF BURIAL, 4-21.., 1921

20-UNDERTAKER E & B Hall

ADDRESS 115 E West St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53063

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53063

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 Mc Donough St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dillman

(a) RESIDENCE. NO. 933 Mc Donough ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&O

(b) General nature of Indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Steven Dillman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Teresa Stokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Mary Dillman 933 Mc Donough St

15 Filed APR 20 1921 ROBERT J. KRAUER Registrar
Burial Permit Oleth

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1921

17 I HEREBY CERTIFY, That I attended deceased from March 31. 1921. to Apr 19. 1921. that I last saw h[illegible] alive on Apr 16. 1921. and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dotenia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Edward Dishis M. D.

4-1921 (Address) 1612 E monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Burks Ville Va	April 21 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53064

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST.; 14 WARD) 152 REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby — Moses.

(Residence in Baltimore: No. S. Bernard Apt, Eutaw Place & the Park St.; 1 hour yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April (Month) 20 (Day), 1921 (Year)

7-AGE, 1 hour. If LESS than 1 day, ...hrs. or....min.?

.....yrs.....mos.....ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Herbert L. Moses.

11-BIRTHPLACE OF FATHER (State or Country), North Carolina.

12-MAIDEN NAME OF MOTHER Stella Rothschild

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norman E. Tannenbaum

(Address) Womans Hospital

15-

Filed APR 20 1921, 191... ROBERT F. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 20 2.50 a.m. 1921, to April 20 3.00 a.m. 1921, that I saw him alive on April 20 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

Left

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Operative delivery

(Duration) ~~....yrs.....mos.....ds.~~

(Signed) Norman E. Tannenbaum M. D.

....., 191... (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balt Hebrew Cem. DATE OF BURIAL, April 20th, 1921

20-UNDERTAKER David Sondheim ADDRESS 1418 W. Mt Royal Ave

Stmc—6-9-19—H. P. Co.—1000 Bks.

D 53065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79-09 D 53065

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Slaughter

(a) RESIDENCE. No. 520 Lemmon St., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	B.	S.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of — Knight

6 DATE OF BIRTH (month, day, and year) 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress. 041
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Slaughter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mrs. Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Joseph Slaughter
(Address) 558 Carlton St

15 Filed 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18/21

17 I HEREBY CERTIFY, That I attended deceased from 4/5, 19 21, to 4/17, 19 21, that I last saw h[illegible] alive on 4/17, 19 21, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (primary)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 520 Lemmon St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) [illegible] M. D.

4/17, 19 21 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Mt Auburn APR 19 1921

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of c

be properly classified. Exact statement of OCCUPA-
k of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D 53066

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3115 Dillon (St.:) 1 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Ernestberger

(a) RESIDENCE. No. 3115 Dillon St., / Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb. 26-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md

PARENTS

10 NAME OF FATHER: George Ernestberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Franklinville Balto Co. Md

12 MAIDEN NAME OF MOTHER: Lilla Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hyattsville Md

14 Informant: George Ernestberger

(Address): 3116 Dillon St.

15 Filed: APR 20 1921

ROBERT J. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 19 1921

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1921, to April 19, 1921, that I last saw h... alive on April 19, 1921, and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Measles

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) ..... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Franklinville Md.	April 21 1921

20 UNDERTAKER: H. Sander & Sons

ADDRESS: 1710 Flat St.

mation should be carefully supplied. AGE, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47638
D 53067

CERTIFICATE OF DEATH.

152 D 53067

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Hayman

(a) RESIDENCE. NO. 1106 E. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16-21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Morris Hayman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Molly Einhorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) John Hopkins Hospital

15 Filed APR 20 1921 ROBERT I. KRAUTER Registrar Social Service Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from April 9 1921, to April 20 1921, that I last saw her alive on April 20 1921, and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Birth Injury).

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. Assn.

DATE OF BURIAL April 20 1921

20 UNDERTAKER Levinson

ADDRESS 1127 E. Baltimore St

mation should be carefully supplied. Any error CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53068

CERTIFICATE OF DEATH.

120 D 53068

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Light ST.; 73 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Taylor

(Residence in Baltimore: No. 924 Light St.; 25 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Feb. (Month) 25 (Day), 1875 (Year)

7-AGE, 46 yrs. 1 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House-wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Lancaster Co. Va

PARENTS.

10-NAME OF FATHER, Thomas C. Callahan.

11-BIRTHPLACE OF FATHER (State or Country), Lancaster Co Va

12-MAIDEN NAME OF MOTHER Willia A Jones

13-BIRTHPLACE OF MOTHER (State or Country), Richmond Co Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard H. Taylor

(Address) 924 Light St

15- [illegible]

Filed....., 191..... Registrar.

APR 26 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 19 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 7th 1921, to April 19th 1921, that I saw her alive on April 18th 1921, and that death occurred, on the date stated above, at 5:54 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonar Hemorrhage

Pneumonia

(Duration) 2 yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 3 yrs. Indefinite mos. 12 ds.

(Signed) Hugh B. Wallace M. D.

April 20th, 1921. (Address) 120 E Light

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Cedar Hill	Apl. 21., 1921
20-UNDERTAKER John H. Denny	ADDRESS 715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53069

CERTIFICATE OF DEATH.

92 D 53069

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 Augusta Ave ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ames

(a) RESIDENCE. No. 132 Augusta Ave ST., 26 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1-1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Alvin Ames

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Catherine Engle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant A G Ames
(Address) 132 Augusta Ave

15 Filed . 19 ROBERT P. KRAUTER Registrar

APR 20 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 17, 1921, to Apr 19, 1921, that I last saw her alive on Apr 19, 1921, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W A Krell, M. D.

4/21, 1921 (Address) 4207 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Apr 21 1921
20 UNDERTAKER	ADDRESS
Wm J Pickrell Sons	North & Pa

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53070

CERTIFICATE OF DEATH.

37

D 53070

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Cardner

(a) RESIDENCE. No. 841 Ostend St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prince George Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Gardner

11 BIRTHPLACE OF FATHER (city or town) Prince George
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Henson

13 BIRTHPLACE OF MOTHER (city or town) Prince George
(State or country) Maryland

14 Informant Hospital Records,
(Address) New City Hospital.

15 FILED APR 20 1921 REGISTRAR OF VITAL STATISTICS
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1921 to April 19, 1921, that I last saw her alive on April 18, 1921, and that death occurred, on the date stated above, at 5:00 A.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver
(Cystic)

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Syphilis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What confirmed diagnosis? No especial test.

(Signed) Chas H Eyman, M. D.

4/19/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 22 1921
20 UNDERTAKER	ADDRESS 916
David Easton	Balto

mation should be carefully supplied. Arts and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Apmc—6-9-19—M. F. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53071

CERTIFICATE OF DEATH.

47 ✓D 53071

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 443 W. 26th. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Kirkpatrick

(a) RESIDENCE. NO. 443 W 26th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Kirkpatrick

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant James H Kirkpatrick
(Address) 443 W 26th St

15 Filed APR 20 1921 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to April 19, 1921, that I last saw her alive on April 19, 1921, and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. Judy mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Senility 6 wks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. C. Richardson, M. D.

April 20, 1921 (Address) 112 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cem	Apr 22 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Monument

N. B.—WRITE PLAINLY, with pen and ink. PHYSICIAN should be careful to see that AGE is correctly stated. EXACT information should be carefully supplied. AGE should be stated EXACTLY. Fractions of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53072

CERTIFICATE OF DEATH.

138 ✓ D 53072

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Farek Hunn, Mrs.

(a) RESIDENCE. No. 580 North Wadeira St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Paul Hunn

6 DATE OF BIRTH (month, day, and year) April 12, 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ?

12 MAIDEN NAME OF MOTHER Anna Pica

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant Johns Hopkins Hospital (Address) Record

15 Filed APR 20 1921 ROBERT I. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1921, to April 19, 1921, that I last saw her alive on April 19, 1921, and that death occurred, on the date stated above, at 9:00 a. m.

The CAUSE OF DEATH* was as follows:

Toxemia following pregnancy, one month ago. Acute symptoms preceded death only 12 hrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 580 No. Meideira St.

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy not yet completed

(Signed) Henry M. Thomas Jr M. D.

4-19-1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Apr 22 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E. N. Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of INFOR-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

D 53073

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 53073

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1529 Edmondson Ave ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Littleton Chandler Baudy

(Residence in Baltimore: No. 1529 Edmondson Ave, St.: 65 yrs., 3 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, January 21, 1856
(Month) (Day) (Year)

7-AGE, 65 yrs. 3 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cashier
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Andrew J. Baudy

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Ann E. Baudy

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. A. Brashear

(Address) 2809 Maryland Ave

15- APR 20 1921 Filed ..... 191.....

ROBERT F. KRAUTH
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) I find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage 5 minutes

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. D. Hennegan M. D.
(Coroner.)

April 19, 1921 (Address) 2502 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery

DATE OF BURIAL, Apr. 21 1921

20-UNDERTAKER George J Smith

ADDRESS 1000 Fayette St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

3074

CERTIFICATE OF DEATH.

151 D 53074

1-PLACE OF DEATH (

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. St.: 11 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lawsuan

(a) RESIDENCE. No. Md Gen'l Hosp. St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 0

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 0 hrs. or 24 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer 0

9 BIRTHPLACE (city or town) Baltimore. Md

(State or country)

PARENTS

10 NAME OF FATHER Emory H Lawsuan

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Clara S. Thomas,

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Father - 5006 - 27th St.

(Address)

15 Filed APR 20 1921 ROBERT F KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 19 1921

17

I HEREBY CERTIFY, That I attended deceased from 4-19, 1921, to 4-19, 1921, that I last saw h[illegible] alive on 4-19, 1921, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 0

Did an operation precede death? 0 Date of

Was there an autopsy? 0

What test confirmed diagnosis? Clinical Manifestations

(Signed) R. H. Richardson, M. D.

, 19 (Address) Md. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md General Hospital	APR 20 1921
20 UNDERTAKER	ADDRESS
Commissioner Health.	

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53075 CERTIFICATE OF DEATH. 15 28 D 53075

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Wise

(a) RESIDENCE. NO. 1307 N. Stockton st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not recorded

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chef 670

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Texas

PARENTS

10 NAME OF FATHER: Thomas Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Texas

12 MAIDEN NAME OF MOTHER: Nealy McCann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Texas

14 Informant: Hospital Records (Address) M.T.H.

15 Filed APR 20 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1921, to April 17, 1921, that I last saw him alive on April 16, 1921, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary): Tuberculous broncho-pneumonia (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum. X-ray

(Signed) L. Tagney, M. D.

4-18-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL: APR 20 1921

20 UNDERTAKER: Commissioner Health. ADDRESS

Wm. C. WOODALL

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53076

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 53076

CERTIFICATE OF DEATH

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Raymond Starks ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 ~~FULL NAME~~ 1103 Brewer

(Residence in Baltimore: No. 1103 Brewer St.: yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Col	—

6 DATE OF BIRTH Oct. (Month) 14 (Day), 1920 (Year)

7 AGE — yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Henry Henderson

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Starks

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Henderson

(Address) 1108 Brewer St

15 Robert P. Harrison,

Filed APR 20 1921, 191 Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. (Month) 17 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1921, to Apr. 17, 1921, that I saw h[illegible] alive on Apr. 17, 1921; and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:—

Broncho-Pneumonia

(Duration) — yrs. — mos. 3 ds

Contributory (SECONDARY) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Frank E. Wagner M. D.

Apr. 20, 1921 (Address) 1056 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Asbury Cem. DATE OF BURIAL Apr 20 1921

20 UNDERTAKER Harry A. Vodery ADDRESS 1745 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.53077 HEALTH DEPARTMENT—CITY OF BALTIMORE D.53077

CERTIFICATE OF DEATH. 54

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 117 S Chester ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Milewski

(a) RESIDENCE. No. 117 S Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 30 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 21 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wladyslaus Milewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wladyslawa Piotrkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wladyslaus Milewski
(Address) 117 S Chester

15 Filed ..... 19.. Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1921

17

I HEREBY CERTIFY, That I attended deceased from April 17th 1921 to Apl 20 1921, that I last saw him alive on April 19th 1921, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Counts

(Signed) Gustav Weber, M. D.

19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 21 1921
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

mation should be carefully supplied. Any [illegible] it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53078

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53078

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1512 Byrd St ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M Commaney

(a) RESIDENCE. No. 1512 Byrd ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm A Commaney

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Geraldine M Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Wm A Commaney (Address) 1512 Byrd St

15 Filed APR 20 1921 19.. Robert F. Harris Registrar

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1921, to April 20, 1921, that I last saw h... alive on April 20, 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. R. Campbell M. D.

April 20 1921 (Address) 1604 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	April 1921
20 UNDERTAKER	ADDRESS
Wm Cahoon & Mattern	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53079

CERTIFICATE OF DEATH.

REGISTERED NO. 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 E. Fairmount Ave ST. 6 WARD)

2-FULL NAME Florence Ingram

(a) RESIDENCE. No. 1416 E. Fairmount Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: married Charles Ingram

6 DATE OF BIRTH (month, day, and year): July 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Arlington, Va.

PARENTS

10 NAME OF FATHER: B. F. Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alexander Va.

12 MAIDEN NAME OF MOTHER: Susie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Arlington Va.

14 Informant: Charles Ingram

(Address): 1416 E. Fairmount ave

15 Filed: Robert P. Harrison, Registrar

PR 20 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 18 Apr. 1921

17 I HEREBY CERTIFY, That I attended deceased from 12 Apr., 1921, to 18 Apr., 1921, that I last saw h[illegible] alive on 18 4, 1921, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows: Infected sore on buttock, hypostatic congestion of both lungs, etc. About 6 days

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Heart failure General Conv.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Murrayfield Boyle, M. D.

19/4, 1921 (Address) 424 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	April 21 1921

20 UNDERTAKER: R. C. Gross ADDRESS 1405 McElderry St

mation should be carefully supplied. Age should be stated EXACTLY. It may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53080 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53080

CERTIFICATE OF DEATH. 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret Miller

(a) RESIDENCE. NO. 521 N. Castle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 3 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 29 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Andrew Frahm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Margaret Eckel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Geo Miller
(Address) 521 N Castle

15 Filed APR 22 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19 19 21

17 I HEREBY CERTIFY, That I attended deceased from 3/31 19 21, to 4/19 19 21,
that I last saw h[illegible] alive on 4/19 19 21,
and that death occurred, on the date stated above, at 12.30 P. m.
The CAUSE OF DEATH* was as follows:

Abrasion - Intestinal
Obstruction - following old
Appendectomy (duration) yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary) Malnutrition
(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? 4/4/21 4/19/21

Did an operation precede death? Yes Date of 4/19/21

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Emma L. Kelly, M. D.

4/19 19 21 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL Apr 22 1921

20 UNDERTAKER J. Henry & Co

ADDRESS 2008 Eutaw

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

D 53081

Spec.—6-9-19—H. P. Co.—1000 Bks.

D/53081

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 S. 2nd St. ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dunnuck

(a) RESIDENCE. No. 901 S. 2nd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) 4/5/21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

16 NAME OF FATHER John H Dunnuck

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Seibert

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) md

14 Informant John H Dunnuck
(Address) 901 S. 2nd St

15 Filed Robert P. Harrison, Registrar

APR 21 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1921

17

I HEREBY CERTIFY, That I attended deceased from 4/15, 1921, to 4/20, 1921, that I last saw h e alive on 4/20, 1921, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6 mo. uterogestation
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Kahnweiler M. D.

4/20 1921 (Address) 3035 O'Donnell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Apr 21 1921
20 UNDERTAKER J Herwig & Co	ADDRESS 1008 Aliceanna

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53082 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53082

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1632 W. Balto. St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Marie Harten

(a) RESIDENCE. No. 1632 W Balto. St.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Harten

6 DATE OF BIRTH (month, day, and year) Jan. 8th 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, md.

12 MAIDEN NAME OF MOTHER Katherine Schmelzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore md.

14 Informant Herman Harden
(Address) 1632 W Balto St

15 Filed Apr 20 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1921 to April 19 21, that I last saw her alive on April 19 1921, and that death occurred, on the date stated above, at 5.9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 10 mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) E Hilbert Hemming M. D.

20 1921 (Address) 2000 Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Apr. 22nd 19 21
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St

CAUSE OF DEATH should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53083 ✓ 100-09 D 53083

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jonas Wolfe Hechinger

(Residence in Baltimore: No. Hebrew Hospital St.; — yrs., 3 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, March 8, 1854. (Month) (Day) (Year)

7-AGE, 67 yrs. 1 mos. 12 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Dry Goods 0 45

9-BIRTHPLACE, (State or Country), Schuylerspot La.

PARENTS.

10-NAME OF FATHER, Solomon Hechinger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Bettie Marks

13-BIRTHPLACE OF MOTHER (State or Country), German

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Hechinger

(Address) Washington DC

15-

APR 21 1921 ROBERT J. BRAUTEN

Filed, ... 191.....

Burial Permit Issued ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 6 1921, to April 20 1921, that I saw h him alive on April 20 1921, and that death occurred, on the date stated above, at 7 30 p.m.

The CAUSE OF DEATH* was as follows:

Streptococcus sore throat

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerotic Gangrene

Right foot (Duration) ..... yrs. 3 mos. 14 ds.

(Signed) Louis Sachs M. D.

April 20, 1921. (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. 3 mos. 14 ds. In the State — yrs. 3 mos. 14 ds.

Where was disease contracted, if not at place of death? D C

Former or usual residence Washington DC

19-PLACE OF BURIAL OR REMOVAL, Washington DC DATE OF BURIAL, April 21, 1921.

20-UNDERTAKER Harry Sondheim ADDRESS 1108 N. Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. D. C.—1000 Blks.

D 53084

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53084

CERTIFICATE OF DEATH.

REGISTERED NO. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kruger

(a) RESIDENCE. No. 901 N Broadway, Parkway WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 17/1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Kruger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mildred Arold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Kruger
(Address) 901 Parkway

15 Filed APR 21 1921 19 [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 19 21

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 19 21, to 4/20, 19 21,

that I last saw h[illegible] alive on 4/20, 19 21,

and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lucius D. Rogers, M. D.

4/21 19 21 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon	April 21, 19

20 UNDERTAKER ADDRESS

Wm. Miss & Sons, 1015 N. P[illegible]

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53085

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53085

CERTIFICATE OF DEATH.

28

REGISTRATION NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 W. Fayette ST. 20 WARD)

2-FULL NAME Mamie Emory

(a) RESIDENCE. No. 1914 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph A. Emory

6 DATE OF BIRTH (month, day, and year) Aug 2, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wool 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John R. Delaney

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Annie E. Dunphy

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant John R. Delaney (Address) 1914 W. Fayette St

15 Filed APR 21 1921, 19.. ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH 20

16 DATE OF DEATH (month, day, and year) April 20 19 21

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 19 20, to April 20, 19 21,

that I last saw h[er] alive on April 19, 19 21,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyle, M. D.

April 22, 19 21 (Address) 602 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 23 1921
20 UNDERTAKER George J. Smith	ADDRESS 1806 Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53086

6-041

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 S Potomac ST. 1 WARD)

2-FULL NAME Richard G Zorn

(a) RESIDENCE. NO. 729 S Potomac ST. 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year) Nov. 7-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Andrew J Zorn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Lillian M Duggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant Andrew Zorn

(Address) 729 S Potomac St

15 Filed APR 21 1921 ROBERT I. KRAMER Registrar

Burial ... Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 14. 1921, to April 20. 1921, that I last saw him alive on April 20 1921, and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

Measles.

(duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) / yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Skin Eruption

(Signed) R. T. Hardesty, M. D.

, 19 (Address) 1202 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	April 22 1921
20 UNDERTAKER	ADDRESS
Stephen J Fialkowski	1050 Kenwood

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53087 ✓ D 53087

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 E. Madison ST.: 10 WARD)

2-FULL NAME Howard Albert McClain

(a) RESIDENCE. NO. 1208 E. Madison ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 6/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Howard McClain

11 BIRTHPLACE OF FATHER (city or town) Shamokin (State or country) Pa

12 MAIDEN NAME OF MOTHER Ruth Brown

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Howard McClain
(Address) 1208 E. Madison St

15 Filed APR 21 1921 ROBERT I. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1921

17 I HEREBY CERTIFY, That I attended deceased from apr 18, 1921, to apr 19, 1921, that I last saw him alive on apr 19, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) d. h. Hornstein, M. D.

4/20. 1921 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 21 1921
20 UNDERTAKER Henry Lutz	ADDRESS 1007 N. Bond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53088

CERTIFICATE OF DEATH.

28 D 53088

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1317 Hollins St. 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth L. F. Lost

(a) RESIDENCE. No. 1317 Hollins St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Mar.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Harry L. Lost

6 DATE OF BIRTH (month, day, and year) — 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Fred O Buchwald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Margret Kocher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Harry L. Lost 1317 Hollins St

15 FILED APR 21 1921 ROBERT I KRAUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 13, 1921, to Apl 21, 1921, that I last saw h alive on Apl 20, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) J Norwood, M. D.

(Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	4/23/21

20 UNDERTAKER	ADDRESS
W J Smith	1008 W Fayette

mation should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53089

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 419 Lyson ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebraca Dunck

(Residence in Baltimore: No. 419 Lysons St — 25 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colord	Marri'd

6-DATE OF BIRTH, ... Don't Know ! ..... (Month) (Day) (Year)

7-AGE, 29 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), born in St-Mary's Co lies in Baltimore Md 25-years.

PARENTS.

10-NAME OF FATHER, Guyn Barrr

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Chapman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agness Stearens

(Address) 713 Little George St

15- APR 21 1921 Filed ....., 191.... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April ..... 19.., 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... ~~(Inquest, au~~ ..... ~~topsy or~~ inquiry.) find that said deceased came to ..her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart ..... (Duration) ..... yrs. a few hours mos. ..... ds.

CONTRIBUTORY (Secondary) Probably Influenza ..... (Duration) ..... yrs. ..... mos. 2 wks ds.

(Signed) ..... H. K. Gorsuch ..... M. D. (Coroner.)

4..20..., 192.. (Address) 11 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, April 21..., 1921.

20-UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55-001 D 53090

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.: 9 WARD)

2-FULL NAME Mattie Leach.

(a) RESIDENCE. NO. 728 E. 20th St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	abt 59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home. pod

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Benjamin J. Leach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophie Harding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma J. Stroud
(Address) 728 E. 20th St

15 Date APR 21 1921 ROBERT J. BRUNER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1921, to April 20, 1921, that I last saw her alive on April 20, 1921, and that death occurred, on the date stated above, at 12 30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Encephalitis (Lethargica)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. C. Manno, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 23 1921
20 UNDERTAKER William Cook	ADDRESS 5822 Natl Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Bernice Rice

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53091

CERTIFICATE OF DEATH.

9v D 53091

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hannah Jane Hosp St. 47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernice Rice

(Residence in Baltimore: No. 1336 Argyle ave St. Lf. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan. 28, 1919 (Month) (Day) (Year)

7-AGE, 1 yrs. 3 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank Rice

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER Sarah E. Rund

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Rice

(Address) 1336 Argyle ave

15- APR 21 1921 [illegible]

Filed....., 191.... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20th 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 20th 1921, to April 20th 1921, that I saw her alive on April 20th 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

(Diphtheria
Laryngeal)

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Fiske Ellis M. D.

April, 1921 (Address) 924 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Apr. 21, 1921

20-UNDERTAKER Samuel Hemsley ADDRESS 708 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53092

81 V

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St Agnes Hospital St. 16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Houston

(a) RESIDENCE. No. 1001 W Lanvale St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Houston

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired R.R. Officer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Houston

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Frazer

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant H. O. Houston Wife
(Address) 207 S. Bowen & Jackson

15 Filed APR 21 1921 19 ROBERT F. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20-1921

17 I HEREBY CERTIFY, That I attended deceased from 4-15, 1921, to 4-20, 1921, that I last saw h[illegible] alive on 4-20, 1921, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Senility

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. W. H. Mary M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedarcroft Md	April 21 1921

20 UNDERTAKER John O. Mitchell ADDRESS 150 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53093 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 53093

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2411 Orleans St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth ~~Campbell~~ Mc. Sweeney

(a) RESIDENCE. NO. 2411 Orleans ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dennis Mc. Sweeney

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Bernard ~~Campbell~~

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Isabell Divney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sarah Mc. Sweeney (Address) 2411 Orleans St.

15 Filed APR 21 1921 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to April 20, 1921, that I last saw her alive on April 18, 1921, and that death occurred, on the date stated above, at 5.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? — Laboratory

(Signed) Wm J McAvoy M. D.

April 20 19 21 (Address) 836 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 23 1921

20 UNDERTAKER Jos. L. Hess ADDRESS 156 N. Lynnehaven.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr. Mc. Avoy Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 53094

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Marshall ST.: 23 WARD)

2-FULL NAME Henry Rauft

(a) RESIDENCE. No. 1412 Marshall ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? 71 yrs. 8 mos. 4 ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mollie F. Rauft

6 DATE OF BIRTH (month, day, and year) Aug 15, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar-maker

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar manufacturer

(c) Name of employer Mr Deluxon-80 Lexington

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Alexander Rauff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Butterbrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mollie F. Rauff
(Address) 1412 Marshall

15 Filed APR 21 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1921, to April 19, 1921, that I last saw ~~him~~ alive on April 18, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac dilatation

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) ....yrs. ....mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hawkins, M. D.

4/21 1924 (Address) 1 E. Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem Co.	4/22 1921
20 UNDERTAKER	ADDRESS
J. Fenwick McCully	130 E. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53095 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53095

CERTIFICATE OF DEATH. 8-092

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 S Broadway ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jadwiga Malenska

(a) RESIDENCE. NO. 725 S Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Tomas Malenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anela Kulinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Tomas Malenski 725 S Broadway

15 Filed APR 21 1921 ROBERT F. BAUER Registrar

Burial ... (1) ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from June Apr 19" 1921, to Apr 20" 1921, that I last saw her alive on Apr 20" 1921, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping cough

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Kellogett Emerson M. D.

April 21 1921 (Address) 2129 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 22 1921

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

N. B.—ABOVE PARTICULARS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53096

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D 53096

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Sutton Mr James ST.: 225 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto A. Haussler

(Residence in Baltimore: No. Sutton Mr James-Homewood Apts ST.: 35 yrs. 8 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH ..... (Month) ..... (Day) ....., 1885 (Year)

7-AGE 35 yrs. 8 mos. 3 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Mechanic 031
(b) General nature of industry, business, or establishment in which employed (or employer) Decorating Co

9-BIRTHPLACE (State or country) Baltimore, Md

PARENTS

10-NAME OF FATHER Paul Haussler

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Catherine Haussler

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Barbara Haussler

(Address) Sutton Mr James-Homewood Apts

15 APR 21 1921 Filed ..... 191 ROBERT P. KRAUTH Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April (Month) 20 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1921, to April 20 1921, that I saw h-m alive on April 19, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) same

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Geo Tomkinson M. D.

(Address) Homewood Apts

April 20 1921

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park Cemetery

DATE OF BURIAL April 23 1921

20-UNDERTAKER F. C. Bosgart

ADDRESS 2236 Frederick Ave

Spec.—5-19-13—M. & T.—500 Bks.

D 53097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53097

CERTIFICATE OF DEATH.

REGISTERED NO. C 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 205 S. Pulaski ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Isebelein

(Residence in Baltimore: No. 205 S. Pulaski St St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec. 8, 1844. (Month) (Day) (Year)

7-AGE, 76 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Joseph Bergmon

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Isenmacher

(Address) 205 S. Pulaski St

15- APR 21 1921 ACCIDENT OR FRACTURE

Filed ..... 191. Carl Farrell Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apl 19, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apl 18 1921, to Apl 19 1921, that I saw her alive on Apl 18 — 1921, and that death occurred, on the date stated above, at 4.50 p.m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Buchanan M. D.

4/20/21 (Address) 207-8 Professional Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park. DATE OF BURIAL, Apr. 22, 1921.

20-UNDERTAKER Geo. E. Schwab & Bro ADDRESS 210 Eutaw Line

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53098 **CERTIFICATE OF DEATH.** 104 D 53098

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 707 Edmondson Ave St.: 17 WARD)

Registered No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Gordon

(Residence in Baltimore: No. 707 Edmondson Ave St.; yrs., 7 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, August 29, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. 7 mos. 22 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... (Dependent)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS:

10-NAME OF FATHER, Child was adopted from Children's Aid Society

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lilly Gordon

(Address) 707 Edmondson Ave.

15- Filed APR 21 1921, 191.... ROBERT N. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.
The CAUSE OF DEATH* was as follows:

a. Gastro-Enteritis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Rachitis & Tetany

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

April 20, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, APR 2 ....., 19....
20-UNDERTAKER	ADDRESS

HOPKINS HOSPITAL
Commissioner of Health.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53099

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 Aisquith ave ST.; 25 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adaline Gardstas

(Residence in Baltimore: No. Lafayette St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	W	Single

6-DATE OF BIRTH, Oct 19 (Month) (Day), 1920 (Year)

7-AGE, — yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0-0

9-BIRTHPLACE, (State or Country), Baltimore md.

PARENTS.

10-NAME OF FATHER, Joseph Gardstas

11-BIRTHPLACE OF FATHER (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER Anne Surras

13-BIRTHPLACE OF MOTHER (State or Country), Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Gardstas

(Address) 1300 County ave

15- APR 21 1921 Filed....., 191.... ROBERT J. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 20 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 18 1921, to Apr. 20 1921, that I saw her alive on Apr. 19 1921, and that death occurred, on the date stated above, at 1030 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix

(Duration) ...yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) ...yrs. 1 mos. ...ds.

(Signed) A. Krauter M. D.

Ap 21, 1921 (Address) 1340 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL, Sept. 22, 1921

20-UNDERTAKER John Grbelauckas ADDRESS 425 S Paca St.

N. B.—Every item of information should be carefully supplied. AGE must be supplied. Exact statement of OCCUPATION is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53100

CERTIFICATE OF DEATH.

92-079

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Josephs Hospital ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thaddeus Skrzynski (SKRZYNSKI)

(a) RESIDENCE. NO. 575 S. Washington ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 27 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Weronika Skrzynska

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thadeus Skrzynski (Address) 575 S. Washington

15 Filed APR 21 1921 19.....

Burial Permit Issued

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1921, to April 19, 1921, that I last saw him alive on April 19, 1921, and that death occurred, on the date stated above, at 2.55 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Wm. J. Riley, M. D.

, 19 (Address) 1627 North Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 22 1921

20 UNDERTAKER Wm. Galloway & Son ADDRESS East

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53101 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53101

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cozneius Campbell.

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary McMahon.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Daniel Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Fay.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sister Florence, Supr. (Address) Little Sisters of the Poor

15 Filed Apr 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from to record, 19..., to ..., 19...

that I last saw him alive on April 17, 1921.

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Warner, M. D.

21, 1921 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Apr. 22 1921

20 UNDERTAKER H. C. Windfield ADDRESS 914 Gremmel Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 21 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 53102

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 Hollins, St. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. David Bußbaum

(a) RESIDENCE. No. 1206 Hollins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mannie Bußbaum

6 DATE OF BIRTH (month, day, and year) Oct. 22-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Trimmer

(b) General nature of Industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Bußbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Arthur Bußbaum
(Address)

15 Filed APR 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1921

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1918, to Apr 19, 1921, that I last saw h.. alive on Apr 17, 1921, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis, Arteriosclerosis (duration) 2 yrs. 9 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

4/17, 1921 (Address) 1779 Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bolo Hebrew — DATE OF BURIAL Apr 22 1921

20 UNDERTAKER J. Ahrens & Co — ADDRESS Holland

...mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53103

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53103

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Radtke

(a) RESIDENCE. No. 1769 Delaware Ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. Arlington (If nonresident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer) 067

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Charles Radtke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Macy Stevenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed APR 22 1921, 19 Robert [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1921

17

I HEREBY CERTIFY, That I attended deceased from April 18 - 1921 - to April 18 - 1921 - that I last saw her alive on April 18 - 1921 - and that death occurred, on the date stated above, at 4 20 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of left lung & metastasis & perforation into spinal cord

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Yes.

(Signed) [illegible] M. D.

4-19-1921 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Burn — DATE OF BURIAL: April 23 1921

20 UNDERTAKER: Denil Easton — ADDRESS: Ca[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53104

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

D 53104

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH US. Public Health Hosp. #56 Fort McHenry Baltimore Md.

CITY OF BALTIMORE: (No. 304 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert P. Simmons

US. Public Health Hosp. #56 Fort McHenry Baltimore Md.

(a) RESIDENCE. NO. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs R P. Simmons

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	--	--	--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business, or establishment in which employed (or employer): ----

(c) Name of employer: ----

9 BIRTHPLACE (city or town) (State or country): S.C.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Edgar T Rosenbrock Registrar

(Address): US. Public Health Hosp. #56

15 Filed: Robert P. Harrison, Registrar

APR 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1921, to April 20, 1921, that I last saw him alive on April 20, 1921, and that death occurred, on the date stated above, at 215 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far adv. & active

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ----

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Thomas B. Payne M. D.

Senior Surgeon (R)

, 19 (Address) US. Public Health Hosp. #56

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Helen bur	April 22 1921
20 UNDERTAKER Denis Easton	ADDRESS 416 St ave

mation should be carefully supplied. AGE should be stated IMMEDIATELY after birth. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53105

D 53105

CERTIFICATE OF DEATH.

REGISTERED NO. 76

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Mac Donnell

(a) RESIDENCE. No. 1702 E. Preston St. St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry R & Ruby L. Mac Donnell (Parents)

6 DATE OF BIRTH (month, day, and year) July 16, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry Mac Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ruby L. Boden.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital

15 Filed APR 21 1921, 19 Registrar

Burial Permit Issued

Robert F. Harris, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 14. 1921, to April 20. 1921, that I last saw her alive on April 20. 1921, and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Otitis Media

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Septicaemia and Meningitis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood culture & lumbar puncture

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Lorraine Cemetery	April 23 1920
20 UNDERTAKER	ADDRESS
Wm. J. Hartley	845 Washington St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53106

CERTIFICATE OF DEATH.

D 53106

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2916 Allendale Rd. I.: 15 WARD) REGISTERED NO. 78

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Moale

(a) RESIDENCE. NO. 2916 Allendale Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Moale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER May E Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John Moale
(Address) 2916 Allendale Rd.

15 Filed APR 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Apl 13, 1921, to Apl 20, 1921, that I last saw h.im alive on Apl 20 (7 p.m.), 1921, and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Acute endo-Carditis - (3rd attack)

over

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Valvular defects from previous attack + Anuria (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) Robert W. Steffin, M. D.

, 19 (Address) 2916 Mad. Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	April 22 1921
20 UNDERTAKER	ADDRESS
Henry H Jenkins & Son	Eutaw & Mc Collh St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
TION is very important. See instructions on back of certificates.

1016 Madison Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—8-24-14—M. & T.—2000 Blks.

D 53107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 53107

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 248 S. Caroline St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon H. Chason

(Residence in Baltimore: No. 248 S. Caroline street St.; 35 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unkown, 1 (Month) (Day) (Year)

7-AGE, 76 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clothing
(b) General nature of industry, business, or establishment in which employed (or employer): Presser

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unkown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unkown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Chason

(Address) 248 S Caroline St

15- APR 22 1921 Filed ..... 191.... ROBERT J. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21st, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1914 191 to April 18 1921, that I saw h— alive on April 18 191—, and that death occurred, on the date stated above, at 12¼ m.

The CAUSE OF DEATH* was as follows:

Ills. diffused nephritis

Enlarged Heart

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Sclerosis

(Duration) yrs. 1 mos. ds.

(Signed) M. Shedeck M. D.

4-21, 1921 (Address) 238 Mad av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Cemetery

DATE OF BURIAL, 4-22, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53108

CERTIFICATE OF DEATH.

130 D 53108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 S. Clinton St. 26 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Hanus

(Residence in Baltimore: No. 1016 S Clinton St.; (a) 38 yrs. ..... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. March 24, 1883 (Month) (Day) (Year)

7-AGE. 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country). Moravia

PARENTS.

10-NAME OF FATHER. Frank Zak

11-BIRTHPLACE OF FATHER (State or Country). Moravia

12-MAIDEN NAME OF MOTHER Mrs. Hrom

13-BIRTHPLACE OF MOTHER (State or Country). Moravia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stefan Smetana

(Address) 1016 S. Clinton St.

15- APR 22 1921 Filed ....., 191... ROBERT J. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1921, to April 20 1921, that I saw h[e] alive on April 20 1921, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(Duration) ..... yrs. Unknown mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. Unknown mos. ..... ds.

(Signed) Frank L. Jamgochian M. D.

April 22, 191... (Address) 246 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer

DATE OF BURIAL. April 22, 1921

20-UNDERTAKER Frank Trunk Son

ADDRESS 1916 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53109

CERTIFICATE OF DEATH.

135 D 53109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maternity St.; 22 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Maleo

(Residence in Baltimore: No. 504 S. Paca St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. (Month) 8 (Day), 1882 (Year)

7-AGE, 38 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Lorenzo Noto

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosalia Bonaventura

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John D'Imperio

(Address) 226 S Howard street

15- Filed APR 22 1921, 1921 ROBERT J. KRAUTER Burial Permit Recorder

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 19 1921, to Apr 20 1921, that I saw h[er] alive on Apr 20 1921, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Placenta Previa Centralis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Luigi D'Stefano M. D.

Apr 20, 1921 (Address) 407 N Paca St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral | DATE OF BURIAL, April 22, 1921

20-UNDERTAKER John J Haberson | ADDRESS 1318 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Kamcaums

D 53110

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53110

CERTIFICATE OF DEATH.

4 28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 716 W Lombard St.; WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter P Kamcaums

(Residence in Baltimore: No. 716 W Lombard St.; 25 St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb (Month) 12 (Day), 1853 (Year)

7-AGE, 38 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Sailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Kamcaums

(Address) 716 Paul & Lombard St

15- APR 22 1921 ROBERT J KRAUTER

Filed....., 191.... Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, au~~ ~~topsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hamorrage

Dont Know (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ....yrs....mos....ds.

(Signed) H K Tomasello M. D. (Coroner.)

4-24, 1921. (Address) 117 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, April 23, 1921

20-UNDERTAKER Geo Kleinbach & Son

ADDRESS 647 N Gilmor St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If under 1 day, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 D 53111

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 Ploner St ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lindsay

(a) RESIDENCE. No. 832 Ploner St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 47 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va Live in Baltimore 15 years

PARENTS

10 NAME OF FATHER Robert Lindsay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Willie Lindsay Brother
(Address) 832 Ploner St

15 Filed APR 22 1921 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1921, to April 21, 1921, that I last saw h[illegible] alive on April 20th, 1921, and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia
General peritonitis

(duration) yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Stall M. D.

, 19 (Address) 1126 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr-Auburn Cem

DATE OF BURIAL April 22 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1715 Ashland Ave

CAUSE should be stated EXACTLY. PHYSICIANS should
mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

D 53112 HEALTH DEPARTMENT—CITY OF BALTIMORE 150 D 53112

CERTIFICATE OF DEATH. REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1122 N. Calhoun St.; 16 WARD)

2-FULL NAME Elsie L. Rusk St.: yrs., mos. 4 ds.)

(Residence in Baltimore: No. 1122 N. Calhoun St

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, April 18, 1921 (Month) (Day) (Year)

7-AGE, yrs. mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Infant

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS

10-NAME OF FATHER, Walter Rusk

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER Carrigault

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Carrie Rusk

(Address) 1122 N. Calhoun St

15- APR 22 1921 ROBERT A KRAUTH Registrar

Filed ....., 191... Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus Trismus Oral

(Duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) J. A. Hennessy M. D. (Coroner)

April 21, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, April 23, 1921

20-UNDERTAKER Wm R A Elliott ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be entered, applied for, or answered, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53113

OK, D 53113
H K Gorsuch
coroner

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+61

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Fowler

(a) RESIDENCE. No. New Windsor Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Windsor Maryland

PARENTS

10 NAME OF FATHER Geo W. Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant H H Barnhart

(Address) Westminster

15 [illegible] 19 [illegible]

APR 22 1921 ROBERT J. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1921

17

I HEREBY CERTIFY, That I attended deceased from April 21, 1921, to April 22, 1921, that I last saw him alive on April 22, 19....., and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Septic Meningitis (Pneumococcic)

(duration) yrs. mos. 3, ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. B. Geyer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pipe Creek cemetery	April 24, 1921
20 UNDERTAKER	ADDRESS
H H Barnhart & Son	Westminster

mation should be carefully supplied. Exact statement of the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 53114

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53114

CERTIFICATE OF DEATH.

152

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 E. Fairmount St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Elenne Dissler

(Residence in Baltimore: No. 1926 E. Fairmount St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 18, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 3 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... none .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Melvin Dissler

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Ruth McAlexandria

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Melvin E. Dissler

(Address) 1926 E. Fairmount St

15- Filed APR 22 1921, 191.... ROBERT J. KRAUTER Registrar

N.B.—Every item of information should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 18 1921, to April 21 1921, that I saw h.. alive on April 21 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Carbuncle about face
..... empyema of Brain
..... (Duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
4/21, 1921. (Address) 2600 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cem. | DATE OF BURIAL, Apr. 22, 1921

20-UNDERTAKER Philip Herrig | ADDRESS 2016 Orleans St.

Burial Permit Issued

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53115 ✓ D 53115

CERTIFICATE OF DEATH.

REGISTERED NO. 79

D 53115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S. Bouldin ST. 26 WARD)

2-FULL NAME Friedericka Baker

(a) RESIDENCE. NO. 318 S. Bouldin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Baker

6 DATE OF BIRTH (month, day, and year) Mar 7, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Forstman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Stalen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. Baker
(Address) 318 S. Bouldin St

15 Filed APR 22 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 — 1921

17 I HEREBY CERTIFY, That I attended deceased from April 6 —, 1921, to April 20, 1921, that I last saw h-r alive on April 20, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Valvular - Cortical Dis - Chronic
Senile Art. Deg —

a (duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) a Nephritis Chronic Interstitial (duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Jas. A. Bowles, M. D.

4/21/1921 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem	Apr 24 1921
20 UNDERTAKER Philip Stewart	ADDRESS 2016 Orleans St

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... at it may be properly classified. Exact statement of OCCUPA... on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53116 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53116

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital ST.; 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. John L. Stam

(a) RESIDENCE. NO. St. Joseph's Seminary WARD. Balto. Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Priest

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	Do not know		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 065

(b) General nature of industry, business, or establishment in which employed (or employer) Priest

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Rev. Fr. Satorelli (Address) St. Joseph's Seminary

15 Filed APR 22 1921 ROBERT I. [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1920 to April 20, 1921, that I last saw h[illegible] alive on " 20 1921, and that death occurred, on the date stated above, at 7:00 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis.
involving lungs intestines
+ larynx

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Craig, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Apr 28 1921
20 UNDERTAKER	ADDRESS
[illegible] Sons	[illegible] N

mation should be carefully supplied. Any amount may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53117

CERTIFICATE OF DEATH.

79 D 53117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women's Home St.; 19 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E Magruder

(a) RESIDENCE. No. 1400 W Lexington ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 13, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Absalom T. Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Elizabeth C Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Ella F Jones Matron
(Address)

15 Date APR 22 1921 Registrar

N. B.—WRITE PLAINLY. WITH EXCEPTION OF AGE information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 19 21

17

I HEREBY CERTIFY, That I attended deceased from Oct, 1920, to Apl 22, 1921, that I last saw h... alive on Apl 21, 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?.....

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Apr 22 1921 (Address) 939 or Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Apl 23 1921

20 UNDERTAKER George J. Smith ADDRESS 1000 W Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D 53118 HEALTH DEPARTMENT—CITY OF BALTIMORE. D 53118

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 Madison Ave ST.; 14 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine P. Barrington

(Residence in Baltimore: No. 1431 Madison Avenue St.; 20 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept 21, 1853
(Month) (Day) (Year)

7-AGE, 67 yrs. 7 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nun
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER, John T. Barrington

11-BIRTHPLACE OF FATHER (State or Country). Baltimore City

12-MAIDEN NAME OF MOTHER Annie Hubbard

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Arthur Lehew

(Address) 1431 Madison ave

15-

Filed ....., 191.....

1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21st, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 6th 1920, to April 21st 1921, that I saw h.. alive on April 19th 1921, and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri
with Metastasis

(Duration) 1 yr. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) — yrs. — mos. 4 ds.

(Signed) Edgar D. Perkins M. D.

April 21st, 1921. (Address) N. Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Apr. 23 1921
20-UNDERTAKER George J. Smith	ADDRESS 1000 Fayette St

N.B. Every item of information must be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH important. See instructions on back of certificate.

ROBERT N. KRAETER
Burial Permit Officer

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53119

HEALTH DEPARTMENT—CITY OF BALTIMORE

15 2 D 53119

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Nyman

(a) RESIDENCE. NO. 802 N. Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1/2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/21/22

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER George Nyman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Shaklyn N. Y.

12 MAIDEN NAME OF MOTHER Ray Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): George Nyman 802 N. Caroline St.

15 Filed APR 23 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1922

17

I HEREBY CERTIFY, That I attended deceased from 4/21, 1922, to 4/22, 1922, that I last saw him alive on 4/22, 1922, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary): Forceps delivery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Forceps delivery.

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Lauson A. Rodgers, M. D.

4/22 1922 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. DATE OF BURIAL: 4/22 1922

20 UNDERTAKER: Jack Lewis ADDRESS: 1411 Eutaw St.

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53120 ✓ D 53120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (NO. Brooksber ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Walter Brooksber

(a) RESIDENCE. NO. Brooklyn, Md 9th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6 / 1904

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
17	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Brooksber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lula Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant University Hospital Records (Address)

15 Filed APR 22 1921 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1921

17 I HEREBY CERTIFY, That I attended deceased from March 28 1921, to April 19, 1921, that I last saw h.. alive on April 19, 1921, and that death occurred, on the date stated above, at 4.15a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Empyema

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. 12 hrs.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? yes Date of March 29, 1921

Was there an autopsy? No Operation

What test confirmed diagnosis?

(Signed) Cyrus F. Hanne, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery.	4/22/1921
20 UNDERTAKER Margaret G. Flynn.	ADDRESS 1400 Eutaw Pl.

mation should be carefully supplied. Age should be correctly classified. Exact statement of OCCUPATION is very important. See instructions on CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D 53121

D 53121

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1546 Argyle Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anette Mc Sierzlet

(a) RESIDENCE. No. 1546 Argyle Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Wainwright

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	—	—	

8 OCCUPATION OF DECEASED 070

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Hudson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah Marriott (Address) 1546 Argyle Ave

15 Filed APR 22 1921 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1921, to April 19, 1921, that I last saw her alive on April 19, 1921, and that death occurred, on the date stated above, at 1:15 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson, M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Lea	April 22 1921
20 UNDERTAKER Isaac Hensley	ADDRESS 178 N Bond

N. B. ALL BLANKS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53122

CERTIFICATE OF DEATH.

79 D 53122

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 Offord ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ann Bias

(a) RESIDENCE. No. 530 Offord ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER John Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dorcas Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James F Bias (Address) 1318 Etting St

15 Filed APR 22 1921 ROBERT I FEATHERSTONE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 20 April 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to April 20, 1921, that I last saw her alive on April 19, 1921, and that death occurred, on the date stated above, at 12.10 A.M. The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(duration) about a year. yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know of any

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H K French, M. D.

4-22-1921 (Address) 117 W Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Apr 22 1921

20 UNDERTAKER Samuel T Hemsley ADDRESS 578 W Biddle

N. B.—WRITE PLAINLY. Age and all other information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53123 ✓ D 53123

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 346 W Biddle ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace D. Beale

(a) RESIDENCE. No. 346 W Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 7 - 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
17	—	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Horace Beale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tappahannock Va

12 MAIDEN NAME OF MOTHER Minnie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Mrs Lee Pickwick 346 W Biddle

15 Filed APR 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apl 21 et 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 15 1921, to apl 21 1921, that I last saw him alive on apl 20 1921, and that death occurred, on the date stated above, at 4.15 a m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) 1 yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? T.B. in Sputum & Urine

(Signed) Gustav Goldman M. D.

(Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Front Royal Va — DATE OF BURIAL Apr 23 1921

20 UNDERTAKER Samuel T Hemler — ADDRESS 575 W Biddle

Burial Permit Issued

Registrar

Information should be carefully supplied. AGE should be stated EXACTLY. ILLEGIBLE words may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53124

CERTIFICATE OF DEATH.

D 53124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2072 Linden Ave ST.; 13 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Amelia A Leuthauser

(Residence in Baltimore: No. 2072 Linden Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Oct 14 (Month) (Day), 1858 (Year)

7-AGE, 63 yrs. 6 mos. 6 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Emanuel Leuthauser

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Leuthauser

(Address) 2072 Linden Ave

15- Filed APR 22 1921, 191.... ROBERT I KRAUTH Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20th (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15 1914, to April 20th 1921, that I saw h.. alive on April 20th 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Symptoms?

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis P. Hamburger M. D.

April 22nd, 191.. (Address) 120 E Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	Apr 22, 1921

20-UNDERTAKER	ADDRESS
David Graham	118 W Mt Royal

N. B.—Every item of information should be given, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D 53125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53125

175-09

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Pennington Ave & Cedar St. CITY HOSPITAL OR WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME C. Earl Anderson.

(Residence in Baltimore: No. Townsend Ave. Brooklyn Heights. A. A. Co. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, October 11th. 1896., 1 (Month) (Day) (Year)

7-AGE, 24 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman, U. S. A.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Industrial alcohol Co.

9-BIRTHPLACE, (State or Country), Brooklyn A. A. Co. Md.

PARENTS.

10-NAME OF FATHER, John W. Anderson.

11-BIRTHPLACE OF FATHER (State or Country), A. A. Co. Md.

12-MAIDEN NAME OF MOTHER Sarah Pumphrey.

13-BIRTHPLACE OF MOTHER (State or Country), A. A. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Anderson. (father)

(Address) Townsend Ave. A. A. Co. Md.

15- APR 28 1921 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally struck and run over
by automobile license no. 9921.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Apl. 20., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery — DATE OF BURIAL, April 22 1921

20-UNDERTAKER John F. Denny — ADDRESS 715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than 1 day, HOURS or MINUTES must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53126

CERTIFICATE OF DEATH.

D 53126

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Washington

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 67

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed APR 22 1921, 19 ROBERT I. LAWYER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 19 21

17 I HEREBY CERTIFY, That I attended deceased from February 11, 19 04, to April 20, 19 21, that I last saw her alive on April 19, 19 21, and that death occurred, on the date stated above, at 4:15 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No especial test.

(Signed) B Herman, M. D.

4/20/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER Commissioner Health.	ADDRESS APR 22 1921

mation should be carefully supplied. Age should be stated EXACTLY. Information on
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53127

CERTIFICATE OF DEATH.

89 D 53127

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 Eden ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susannah Elton

(a) RESIDENCE. No. 2203 E. Oliver ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of widow

6 DATE OF BIRTH (month, day, and year) Dec 14 - 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Saml Morton

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) md.

12 MAIDEN NAME OF MOTHER Susannah Hunt

13 BIRTHPLACE OF MOTHER (city or town) N. Jersey
(State or country)

14 Informant Louise Wallenmeyer
(Address) 2203 E. Oliver

15 FILED APR 22 1921 ROBT. P. LAMOTTE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 19, 1921, that I last saw h.. alive on April 19, 1921, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Lamb, M. D.

4/22/1921 (Address) 1 E Fondadell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apl 22 1921
20 UNDERTAKER Robt A Turner Son	ADDRESS 1442 W Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Jennie Garzzardi)

HEALTH DEPARTMENT—CITY OF BALTIMORE

123

D 53128

CERTIFICATE OF DEATH.

D 53128

REGISTERED No. C

1-PLACE OF DEATH—Hebrew Hospital

CITY OF BALTIMORE: (No. 2700-Eastern ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Guzzardi (Jennie)

(Residence in Baltimore: No. 2700 Eastern Ave St.; 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, March (Month) 30 (Day), 1886 (Year)

7-AGE, 35 yrs. — mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, John Zeppi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Maria Zeppi

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Guzzarde

(Address) 2700-Eastern Ave

15-

Filed APR 22 1921, 191

ROBERT I KRAUTH
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4-9 1921, to 4-20 1921, that I saw h.. alive on 4-20 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Post-operative shock

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Renal Calculi

(Duration) 5 yrs. mos. ds.

(Signed) Louis Barkin M. D.

April 22, 1921. (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, 4/23, 1921.

20-UNDERTAKER George J. Ruth ADDRESS 1735 Hanford Ave

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53129 — 119 D 53129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1540 Harford Ave St.; 9th WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie B. Schaal

(Residence in Baltimore: No. 1540 Harford Ave. St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 12 (Day), 1884 (Year)

7-AGE, 36 yrs. 10 mos. 7 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nil
(b) General nature of industry, business, or establishment in which employed (or employer): Nil

9-BIRTHPLACE, (State or Country), Bath, Md.

PARENTS.

10-NAME OF FATHER, George A. Schaal

11-BIRTHPLACE OF FATHER (State or Country), Bath, Md.

12-MAIDEN NAME OF MOTHER Sadie E. Coates

13-BIRTHPLACE OF MOTHER (State or Country), Bath, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Schaal

(Address) 1840 Harford Ave

15- APR 22 1921 ROBT. J. KRAUTH

Filed ....., 191.... Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 19, 1921, to April 20 1921, that I saw h[illegible] alive on " " 1921, and that death occurred, on the date stated above, at 10½ m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (Uraemia)

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Epilepsy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George H. Hartman M. D.

April 22, 1921. (Address) 2214 Mayfield Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	4/23/, 1921.

20-UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave

N.B.—Every item of information should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53130

CERTIFICATE OF DEATH.

D 53130

REGISTERED NO. 37

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (NO. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Benson

(a) RESIDENCE. NO. 910 Fedenhall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS TO BE FILLED EXACTLY. PHYSICIANS SHOULD BE CAREFUL THAT ALL ITEMS ARE STATED EXACTLY, WITH UNFADING INK—THE AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. AGE should be stated EXACTLY. PHYSICIANS SHOULD BE CAREFUL THAT ALL ITEMS ARE mation should be carefully supplied. AGE should be stated EXACTLY, WITH UNFADING INK—THE AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Bay View Hospital (Address) Balto, Md.

15 Filed APR 22 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1921, to April 20, 1921, that I last saw h[illegible] alive on April 20, 1921, and that death occurred, on the date stated above, at 5:18 P. m.

The CAUSE OF DEATH* was as follows:

† Myocardial Asthenia Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Senile Arteriosclerosis † (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings.

(Signed) H. Goldsmith, M. D.

4/21/1921 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct.	April 23 1921
20 UNDERTAKER	ADDRESS
S L Brown & Son	1058 W Monto St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53131

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53131

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 843 Ducatel Street ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Caplan

(a) RESIDENCE. No. 843 Ducatel St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron Caplan

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1411 Eutaw St

15 Filed Robert P. Harrison, Registrar

APR 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1921

17 I HEREBY CERTIFY, That I attended deceased from August, 1920, to April 22, 1921, that I last saw h alive on April 21, 1921, and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of hepatic flexure of large intestine

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of Sept 1920

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Jacob Leiter, M. D.

4/22/1921 (Address) 223 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	4/22 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53132

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53132

120

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST.: 27 WARD)

2-FULL NAME Mrs. Anna W. Chenoweth.

(a) RESIDENCE. No. 4913 Park Heights Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wallace Frank Chenoweth

6 DATE OF BIRTH (month, day, and year) Sept 15 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James McVey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ely Vandergriff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant W. Frank Chenoweth

(Address) 4913 Park Heights

15 Robert F. Harrison, Registrar

Burial Permit Clerk.

PR 22 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 18th 1921, to Apr. 21st 1921, that I last saw h[illegible] alive on Apr. 21st 1921, and that death occurred, on the date stated above, at 2:20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Uremia.

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phys. Examination

(Signed) Fred J. Bamfield, M. D.

4/21. 1921 (Address) Md Gen. Hosp. —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	1921
20 UNDERTAKER	ADDRESS
Wm J Tucker & Sons	North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53133

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 6 ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob A. Misker

(a) RESIDENCE: No 226 N Luzerne ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiterman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Bernard Misker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Daniels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edgar C Misker

(Address) 226 N Luzerne

15 Filed APR 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 21, 1921, that I last saw him alive on April 21, 1921, and that death occurred, on the date stated above, at 12-30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. V. Estocmo, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Apr 23 1921
20 UNDERTAKER	ADDRESS
J Kerwin & Co	2008 Eden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53134

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53134

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joanna Seabrook

(a) RESIDENCE. NO. 1406 Reynolds St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Fifty-six mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Richard Seabrook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Rose Lanehart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Dead

15 Filed APR 22 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from April 20 — 1921 — to April 21 — 1921 — that I last saw her alive on April 21 — 1921 — and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Rickets and Tetany

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Acad — DATE OF BURIAL 4/23 1921

20 UNDERTAKER Jno J Dabey & Sons — ADDRESS 318 Light St

mation should be carefully supplied. All blanks should be filled. Name of State
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Dr. E. A. Dunkley

D 53135

HEALTH DEPARTMENT—CITY OF BALTIMORE

8 D 53135

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #933 S. Mount St. 19 WARD)

2-FULL NAME Edna May Sweeney

(a) RESIDENCE. No. 2656 Dulaney ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1st 1920

7 AGE — Years: — Months: 5 Days: 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Raymond J. Sweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Edna A. Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Raymond J. Sweeney (Address) 2656 Dulaney St.

15 Filed ..., 19.. Robert P. Harrison, Registrar

APR 22 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 18, 1921, to Apr. 22, 1921, that I last saw her alive on Apr. 21, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Dunkley M. D.

19 (Address) 14 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: April 23/ 1921

20 UNDERTAKER: H. B. Kepsipet — ADDRESS: 2236 Fredk. Av

nation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53136

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH South Baltimore Gen'l Hospital

CITY OF BALTIMORE: (No. 1213 Light ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Ritgert

(a) RESIDENCE. No. 1523 W. Lombard ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) February 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Aloysius Ritgert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland,

12 MAIDEN NAME OF MOTHER Mary Donnelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant South Baltimore Gen. Hospital (Address) 1213 Light St.

15 Filed Robert ... 19 ... Registrar

R 22 1921 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-13- , 1921, to 4-22- , 1921, that I last saw him alive on 4-22- , 1921, and that death occurred, on the date stated above, at 7.15 m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis
Acute peritonitis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute intestinal obstruction (duration) 10 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 4-13-21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard H. Tolson, M. D.

, 19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Apr 25 21
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Lombard

...mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53137 ✓ D 53137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1201 W Lombard ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Zwanziger

(a) RESIDENCE. NO. 1201 W Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 1, 1874.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John L

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Frederica Browning

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant George Zwanziger
(Address) 1201 W. Lombard St

15 Filed APR 22 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1921, to April 21, 1921, that I last saw him alive on April 19, 1921, and that death occurred, on the date stated above, at 7. 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Sputum

(Signed) Louis F. Mayer, M. D.

4/24, 1921 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apr 25 '21

20 UNDERTAKER	ADDRESS
Harry H. Wetzler	1531 W. Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53138

CERTIFICATE OF DEATH.

167

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 910 n. Dallas ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Broder

(Residence in Baltimore: No. 910 n Dallas St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, Mar 31, 1849
(Month) (Day) (Year)

7-AGE, 71 yrs. 11 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Frederick Broder

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicholas Broder

(Address) 910 N. Dallas St.

15-

Filed ..... Robert P. Harrison, 191.. Registrar.

APR 22 1921

Burial Permit Desk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, cradle farm
Steam escaping in
toilet of (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Died
(Duration) yrs. mos. ds.

(Signed) H. Wm. Loeffler M. D.
(Coroner.)
4-22, 1921 (Address) 1 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Apr. 23, 21

20-UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Lombard

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53139 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-619 D 53139

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Evans

(a) RESIDENCE. NO. 1924 N Castle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Norman Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Eugenia Bena

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Norman Evans
(Address) 1924 N. Castle St.

Filed APR 23 1921, 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21/ 1921

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1921, to April 21, 1921, that I last saw her alive on April 21, 1921, and that death occurred, on the date stated above, at 5-50 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Appearances & P.M. findings

(Signed) Chas. A Donovan, M. D.

, 19 (Address) 5. E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 23 1921
20 UNDERTAKER H. Sanders Sons	ADDRESS 1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D 53140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53140

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (1) Henry P. Hynson

(a) RESIDENCE. NO. Latrobe Cpt. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widowed

6 DATE OF BIRTH (month, day, and year) May 20. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) 025

(c) Name of employer Md. Kent Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Nathaniel T. Hynson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Medford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hosp

15 Filed , 19 Registrar

Robert P. Harrison,

Burial Permit Clerk.

APR 23192

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1921, to April 19, 1921, that I last saw him alive on April 19, 1921, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Diffuse Nephritis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. G. Boyer, M. D.

, 19 (Address) University Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apr. 22 1921

20 UNDERTAKER ADDRESS

John Whitehall 1201 N. Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53141

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2330 E. Chase ST.; 8 WARD) 79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen M. Lewis

(a) RESIDENCE. No. 2330 E. Chase ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry B. Lewis

6 DATE OF BIRTH (month, day, and year) April 30-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER James Curley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER McKnown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harry Lewis

(Address) 2330 E Chase st

15 Filed APR 23 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22nd 1921

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 22, 1921, that I last saw h alive on April 22, 1921, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Ventricular Fibrillation

Endocarditis Chronic Rheumatic

(duration) (yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) M. Lowry, M. D.

4-22-21, 19 (Address) 710 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 25 1921

20 UNDERTAKER Geo. M. Fink & Son,

ADDRESS 811 N Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Cause of A- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53142 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53142

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 N. Milton Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Charles Brown

(a) RESIDENCE: NO. 1739 N. Milton Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (~~or, WIFE of~~) Barbara Brown

6 DATE OF BIRTH (month, day, and year) Aug. 16 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor & Builder

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

*10 NAME OF FATHER Daniel C. Brown

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Dresser

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Barbara Brown
(Address) 1739 N. Milton Ave.

15 Filed 19 Robert P. Harris Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to April 21, 1921, that I last saw h[illegible] alive on April 21, 1921, and that death occurred, on the date stated above, at 8 45 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Chr Myocarditis & Arteriosclerosis

(duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) Wm C Geraghty, M. D.

4/21, 1921 (Address) 203 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Apr. 25th 1921

20 UNDERTAKER Henry Hoen & Son

ADDRESS 1801 E Eager

APR 23 1921 Burial Permit [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53143

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53143

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Cumberland St.: 15 WARD)

2-FULL NAME Paul Alphonse Stumm Jr.

(a) RESIDENCE. No. 707 Cumberland St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 21 Years mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wht	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 21/21

7 AGE	Years	Months	Days	If LESS than 1 day: hrs. or min.

8 OCCUPATION OF DECEASED Child

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Stephonse Stumm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Irene Bartell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs A Stumm
(Address) 707 Cumberland St

15 Filed APR 23 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1921, to Apr. 22, 1921, that I last saw h[illegible] alive on Apr. 21, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

7 Mo. Twin, Premature

21 Hours
(duration) yrs. mos. ds.

CONTRIBUTORY Weakness
(Secondary)
21 Hours
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ed Smith, M. D.

Apr. 23 1921 (Address) 1600 Dr. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Apr 23 1921
20 UNDERTAKER Harry W. Elden	ADDRESS 1944 W. North Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53144 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53144

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 N. Milton Ave ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerite V. Perry

(a) RESIDENCE. NO. 1031 N. Milton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) November 14 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Eli J. Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Katherine Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant M. Albert E. Perry
(Address) 1031 N. Milton Ave

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22d 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1921, to April 22 1921,
that I last saw h.. alive on April 20, 1921,
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yr mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

Signature (Signed) S. Drumaker, M. D.

, 19 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Apr. 25 1921
20 UNDERTAKER	ADDRESS
Henry Storck Son	1301 E Eager St

(Martha Waters)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53145 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53145

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 McCulloh ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Waters

(a) RESIDENCE. No. 1432 McCulloh ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
38				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hilda Waters

(Address) 1432 McCulloch

15 Filed APR 23 1921 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1921, to April 20, 1921, that I last saw h alive on April 20, 1921, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia Lobar

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) As Above

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 1432 McCulloch.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological Exam

(Signed) A Fowler, M. D.

, 19 (Address) 712 S. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 23 1921
20 UNDERTAKER	ADDRESS
Geo. W. Chase & Son	1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53146 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53146

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fremont & Columbia av ST.: 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Simpson

(Residence in Baltimore: No. 1305 S. Carey St.: yrs. 68 ~~mos.~~ 24 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Wh Male

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Marr'd

6-DATE OF BIRTH, March (Month) 28 (Day), 1853 (Year)

7-AGE, 68 yrs. mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thos Simpson

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Maria Ritter

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Simpson

(Address) 1305 S. Carey

15-

Filed APR 23 1921, 19[illegible], Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, au~~ ~~topsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know if any

(Duration) yrs. mos. ds.

(Signed) W. K. Gorsuch M. D. (Coroner)

4-22-1921 (Address) 112 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lauder Park Cem — DATE OF BURIAL, April 25, 1921

20-UNDERTAKER Jos Joerdens Son — ADDRESS 217 S. Paca

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53147

CERTIFICATE OF DEATH.

109 D 53147

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No 1325 W. Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Walraven

(a) RESIDENCE. No. 1325 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elias Walraven

6 DATE OF BIRTH (month, day, and year) April 14. 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Issac Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mr. Frank Walraven

(Address) 1313 W. Lanvale st

15 Filed 19 Robert P. Harris, Registrar

PR 23 1921

Burial Permit [illegible] PR. [POWERS]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1921, to April 21, 1921, that I last saw her alive on April 21, 1921, and that death occurred, on the date stated above, at 9 50 A m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis

(duration) yrs. [illegible] mos. [illegible] ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? / Date of

Was there an autopsy? /

What test confirmed diagnosis? /

(Signed) Wm. F. Norris, M. D.

April 22 1921 (Address) 342 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	April 23 1921
20 UNDERTAKER	ADDRESS
Jos. Jacobs & Son	217 S. Broadway

PLEASE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 53148 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53148

CERTIFICATE OF DEATH.

REGISTERED No. C 135

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel Ellett

(Residence in Baltimore: No. 1021 Boyd St.: 1 yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6-DATE OF BIRTH, September 4, 1900 (Month) (Day) (Year)

7-AGE, 20 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Penna

PARENTS.

10-NAME OF FATHER, David E. Kohler

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. Ellett

(Address) 1021 Boyd St.

15-

Robert P. Harrison,
Registrar.

APR 23 1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Post Partum Hemorrhage

(Duration) 2 hrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Geo. Blades M. D.
(Coroner.)

4/21/21 (Address) 1432 N. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF ~~BURIAL~~, OR REMOVAL,	DATE OF BURIAL,
Easton, Pennsylvania	Apr 23 1921
20-UNDERTAKER William Cook	ADDRESS 502 E. North Ave

I.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53149

CERTIFICATE OF DEATH.

REGISTERED NO. C 157

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1208 Towson St. ST. 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Katzka.

(Residence in Baltimore: No. 1208 Towson St. St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, April 7th. 1866, (Month) (Day) 1 (Year)

7-AGE,	If LESS than 1 day.
55 yrs. --- mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lunch room 086
(b) General nature of industry, business, or establishment in which employed (or employer): proprietor.

9-BIRTHPLACE, (State or Country), Hungary

PARENTS.

10-NAME OF FATHER, John Katzka.

11-BIRTHPLACE OF FATHER (State or Country), Hungary.

12-MAIDEN NAME OF MOTHER Katharine Hiam.

13-BIRTHPLACE OF MOTHER (State or Country), Hungary.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Katzka. (wife)

(Address) 1208 Towson St.

15- Robert P. Harrison,

Filed ..... 191.....

Registrar.

APR 23 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21st. 1921., (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation.
Suicide by hanging.
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs....mos....ds.

(Signed) Otto M. Rembrandt M. D. (Coroner)

Apl. 21., 1921 (Address) 1917 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Cedar Hill Cem	Apl. 23 1921

20-UNDERTAKER	ADDRESS
Margaret E. Flynn	1411 Light St.

Mpsc.—6-9-19—H. P. Co.—1000 Blks.

D 53150 HEALTH DEPARTMENT—CITY OF BALTIMORE 150 ✓ D 53150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 E Lafayette ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby. Dippel

(a) RESIDENCE. No. 1741 E Lafayette ST., 8 WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 22 1924

7 AGE	Years	Months	Days	If LESS than 1 day, / hrs. or min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Vernon B Dippel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Anna B Blaine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Vernon B Dippel
(Address) 1741 E Lafayette ave

15 Filed APR 23 1924 Robert P. Harris
Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1924

17

I HEREBY CERTIFY, That I attended deceased from April 22, 1924, to April 22, 1924,

that I last saw h... alive on ....., 19...,

and that death occurred, on the date stated above, at 4 9' m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Doctor 5 months)

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Congenital Malformation

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B F Herzog md M. D.

April 23 1924 (Address) 1305 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Apr 23 1924
20 UNDERTAKER Robt J Turner	ADDRESS 1424 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1921 D 53151

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Pitcher ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip J. Smallwood

(Residence in Baltimore: No. 606 Pitcher St. St.; 63 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, March (Month) ..... (Day), 1855 (Year)

7-AGE, 66 yrs. 1 mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Newsdealer
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Benj. Smallwood

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ellen Douglass

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Estella Dorsey

(Address) 606 Pitcher St

15- Apr 28 1921 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 21st (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16th 1921, to Apl 21st 1921, that I saw him alive on April 20th 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia (Double)

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Rheumatism

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Estella Dorsey M. D.

Apr 21st 1921 (Address) 606 N. Pitcher St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, McAuley — DATE OF BURIAL, April 24, 1921

20-UNDERTAKER Clarence E. Wright ADDRESS 1364 N Carey St

6.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53152 HEALTH DEPARTMENT--CITY OF BALTIMORE D 53152

CERTIFICATE OF DEATH

92

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 706 North Edon St ST. 10 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Irene Hazell

(Residence in Baltimore: No. 706 North Edon St St.; 1 yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Col. | 5 SINGLE, ~~MARRIED~~ ~~WIDOWED~~ OR ~~DIVORCED~~ (Write the word): Infant

6 DATE OF BIRTH: January (Month) 10th (Day), 1921 (Year)

7 AGE: 1 yrs. 3 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Richard Hazell

11 BIRTHPLACE OF FATHER (State or country): Maryland USA

12 MAIDEN NAME OF MOTHER: Ivy Dommmill

13 BIRTHPLACE OF MOTHER (State or country): Maryland USA

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother

(Address) 706 North Edon St

15

Filed APR 23 1921

Robert P. Harrison, M.D.
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 21st, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1921, to 4/21/21, 191, that I saw h[illegible] alive on 4/20/21, 191, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Double)

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) D. Woodward M. D.

4/21/21, 191 (Address) 6 West Front St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: April 23, 1921

20 UNDERTAKER: R C Gross

ADDRESS: 1405 McElderry St

N. B.—Every item of information should be carefully supplied. Any item which may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53153

D 53153

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Ave & 15 th. Street ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MICHAEL .OTREMBA,

(a) RESIDENCE. NO. 12 Ave & 15 th. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 42 yrs 0 mos. 0 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorotha Otremba,

6 DATE OF BIRTH (month, day, and year) Setmber 16-1833.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day- laboerer,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Skreline,
(State or country) Poland,

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown,

14 Informant John Otremba, (SON)
(Address) # 1744 Bank Street

15 Filed APR 23 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22- 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 15 , 1921, to April 22 , 1921, that I last saw him alive on April 20 , 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Enhoardsus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb V. Illey, M. D.

April 22. 1921 (Address) 100 S. Potterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	Apr 25 1921
20 UNDERTAKER	ADDRESS
M.F. Sadowski.	905 S. Ann St.

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

175018 D 53154

HEALTH DEPARTMENT—CITY OF BALTIMORE D 53154

CERTIFICATE OF DEATH. X 24

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. George Kulp. Metzger.

(a) RESIDENCE. NO. Bedford Pa ST., WARD. Bedford Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 - 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student — Grad

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wilkesbarre Pa.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Andrews Metzger

11 BIRTHPLACE OF FATHER (city or town) Bedford Pa
(State or country)

12 MAIDEN NAME OF MOTHER Mary Estelle Kulp. Married

13 BIRTHPLACE OF MOTHER (city or town) Wilkes Barre Pa
(State or country)

14 Informant Johns Hopkins Hospital Boards
(Address)

15 Filed ..... 19 ..... Registrar .....
APR 23 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 . 1921 . to April 21st . 1921 .
that I last saw h alive on April 21st . 1921 .
and that death occurred, on the date stated above, at 7.10 a m.

The CAUSE OF DEATH* was as follows:

Brain Tumor left temporal region —

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Emaciation —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown —

Did an operation precede death? Yes - Date of Nov. 16 '20

Was there an autopsy? Yes -

What test confirmed diagnosis? Autopsy —

(Signed) H. Schmidt, M. D.

4-21-21, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bedford Pa	April 23 1921

20 UNDERTAKER John O Mitchell ADDRESS 1201 W. Fayette

mation should be carefully supplied. Arts
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

D 53155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53155

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 13 W. Montgomery St. ST.: 22 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oliver Benson.

(Residence in Baltimore: No. 13 W. Montgomery St.

35 ------ St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, November 21st, 1864., 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
56 yrs. 4 mos. 30 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Conductor 073
(b) General nature of industry, business, or establishment in which employed (or employer)..... B. & O. R. R.

9-BIRTHPLACE, (State or Country),
Prince Georges Co. Md.

PARENTS.

10-NAME OF FATHER, Thomas J. Benson.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Martha A. Coxson.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Benson, (wife)

(Address) 439 E. Fort Ave.

15-

Robert P. Harrison,

Filed....., 191.....

APR 23 1921 Burial Permit [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto Reinhardt M. D.
(Coroner.)

Apl. 20..., 1921 (Address) 1017 S. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
CEDAR HILL	APR 23 1921

20-UNDERTAKER	ADDRESS
JOHN F. DENNY	716 LIGHT ST.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53156

152

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Foss

(a) RESIDENCE. NO. 2 Vineyard Lane, Waverly WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 4/17/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salto. Md.

PARENTS

10 NAME OF FATHER Edward Foss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Stuart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salto. Md.

14 Informant Edward Foss
(Address) 2 Vineyard Lane Waverly

15 Filed PR 23 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 1921, to 4/23, 1921, that I last saw h— alive on 4/23, 1921, and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Birth injury)
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) /
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/21/21 (decompression)

Was there an autopsy?

What test confirmed diagnosis? Observation

(Signed) Lewis D. Rodgers, M. D.

(Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	4/23 1921

20 UNDERTAKER Chas. F. Wane & Son 1180 Mt Royal Ave

ADDRESS

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53157

CERTIFICATE OF DEATH.

92 D 53157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 W. Franklin st ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George McCellan Matthews

(a) RESIDENCE. NO. 1315 W. Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Matthews

6 DATE OF BIRTH (month, day, and year) Oct 15. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... mln.
	59	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Manfacturer

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Thurmont Md

PARENTS

10 NAME OF FATHER John Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Julia Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Mary Matthews (Address) 1315 W Franklin st

15 Filed ....., 19.... Robert P. Harrison, Registrar

APR 23 1921 Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1921, to Apr 21, 1921, that I last saw him alive on Apr 21, 1921, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos. ½ ds.

CONTRIBUTORY (Secondary) Lobar pneumonia.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None - physical signs.

(Signed) M Bowman Hood, M. D.

Apr 22. 1921 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 23 1921
20 UNDERTAKER	ADDRESS
Jos Jacobs + Son	217 S. Paca st

mation should be carefully supplied. Exact statement of OCCUPATION may be properly classified, so that it may be properly coded. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53158 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53158

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3301 Foster Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Fleckenstein

(a) RESIDENCE. NO. 3301 Foster Ave ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 8- 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	26	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician 029

(b) General nature of industry, business, or establishment in which employed (or employer) Con. Gas & Elec

(c) Name of employer Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Adam Fleckenstein

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Dunlig

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mary Fleckenstein
(Address) 3301 Foster Ave.

15 Filed Robert P. Harrison, Registrar

R 23 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 19 21

17 I HEREBY CERTIFY, That I attended deceased from April 2[illegible], 1921, to April 21, 1921, that I last saw him alive on April 2[illegible], 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of both Lungs

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tuberculosis.

(Signed) Charles W. Waters M. D.

, 19 (Address) 39 W Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	April 25 19 21
20 UNDERTAKER Lilly & Zirkin	ADDRESS 403 S. Wolfe

Mation should be carefully supplied. All blanks should be filled. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53159

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53159

CERTIFICATE OF DEATH.

135

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 Laurens St. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie E. Simpson

(a) RESIDENCE. No. 1425 Laurens St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred J. Simpson

6 DATE OF BIRTH (month, day, and year) Aug. 5" 1880

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alfred J. Wittmyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Co., Pa.

12 MAIDEN NAME OF MOTHER Catherine Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Alfred J. Simpson
(Address) 1425 Laurens St.

15 Filed Apr 23 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22" 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1921, to April 22, 1921, that I last saw her alive on April 22, 1921, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Collapse following Post Partum Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert L. Driscoll, M. D.

Apr 22, 1921 (Address) 1211 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 25" 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Gilmor St

mation should be carefully supplied. AGE should be stated EXACTLY. Even CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53160

CERTIFICATE OF DEATH.

REGISTERED NO. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Eutaw Place ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Lindell Perkins

(Residence in Baltimore: No. 1604 Eutaw Place St.; 71 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, WIDOWED, ~~OR DIVORCED~~, (*Write* the word.) Widower

6-DATE OF BIRTH, June (Month) 14th (Day), 1854 (Year)

7-AGE, 66 yrs. 10 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Photographer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Palmer Lindell Perkins

11-BIRTHPLACE OF FATHER (State or Country), Burlington, New Jersey.

12-MAIDEN NAME OF MOTHER Catherine Tomlinson

13-BIRTHPLACE OF MOTHER (State or Country), Bristol, Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr Edgar D Perkins

(Address) 1 W. Franklin Street

15-

Filed ..... Robert P. Harrison, 191.....

Registrar.

APR 23 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22nd (Month) (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16th 1921, to April 22nd 1921, that I saw him alive on April 15th 1921, and that death occurred, on the date stated above, at 1130 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ... yrs. ... mos. ... ds.

(Signed) Edgar D Perkins M. D.

April 22nd, 1921. (Address) 1 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Apr 25th, 1921

20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 N. Balto St

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53161 D 53161

53161
64 D 53161

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 N Eden ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Newton Todd

(a) RESIDENCE. No. 1408 N Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie E. Todd Deceased

6 DATE OF BIRTH (month, day, and year) Jan 4 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Maryland

PARENTS

10 NAME OF FATHER James Todd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary Elizabeth Crabb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Maryland

14 Informant George Todd

(Address) 1314 N. Central ave

15 APR 24 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 13 1920 to Apr 22 1921

that I last saw him alive on Apr 21 1921,

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. 4 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Sanderson M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 25 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North ave

should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53162

CERTIFICATE OF DEATH.

119 D 53162

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 Wilson Ave ST.; Graus 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Starling LeRoy Fleming

(Residence in Baltimore: No. 418 Wilson Ave St.; 4 yrs., 8 mos., 16 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sngl

6-DATE OF BIRTH, August 7, 1916 (Month) (Day) (Year)

7-AGE, 4 yrs. 8 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, Andrew [illegible] Gassaway

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Irene C. Fleming

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irene C. Fleming

(Address) 418 Wilson Ave

15. APR 24 1921 COUNTY [illegible] DISTRICT

Filed..... 191 Burial Permit Clerk.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 2 1921, to April 23 1921, that I saw him alive on April 22 1921, and that death occurred, on the date stated above, at 8.10 A.M.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) G. W. T. Bischoff M. D.

April 23, 1921 (Address) 601 Shriver Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. 8 mos. 4 ds. In the State 4 yrs. 8 mos. 4 ds.

Where was disease contracted, if not at place of death? Place of death

Former or usual residence Same.

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Apr. 25, 1921

20-UNDERTAKER Edw. Ruggold — ADDRESS 1463 Carey St

N. B.—Every item of information must be given, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53163 HEALTH DEPARTMENT—CITY OF BALTIMORE 5 Haven St.

CERTIFICATE OF DEATH. D 53163

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mt Hay Maternity Hospital June 100 ST.: 5 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Miller

(Residence in Baltimore: No. 1028 Hillen St.; yrs., mos. ds.) Wid

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March (Month) 29 (Day), 1878 (Year)

7-AGE, 43 yrs. 23 mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): D.

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Geo. Miller

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Adrian

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Miller

(Address) 3120 Pratt.

15- APR 24 1921 Filed, 191 ROBERT F. BAUER Registrar.

Burial

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 21 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Apr. 22, 191 (Address) 16 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Poplar Cem. Balto Co.	Apl 24, 1921
20-UNDERTAKER	ADDRESS
H. Snyder & Sons	1710 Kent St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53164

50 D 53164

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary P. Kantorski

(a) RESIDENCE. NO. 428 S. Chapel ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Stanislaus Kantorski

6 DATE OF BIRTH (month, day, and year) March 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Frank Kaminski

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Martin Warschauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Zuikun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaus Kantorski (Address) 428 S Chapel St

15 [illegible] 19 APR 24 1921 ROBERT A. FRAZIER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1921

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to April 24, 1921, that I last saw h.. alive on April 24, 1921, and that death occurred, on the date stated above, at 1.10 a. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma (Post Operative)

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) Diabetes (duration) yrs. mos. ds.

Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of 4-21-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles S Levy, M. D.

4-24-1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Chapel	4/26/21
20 UNDERTAKER Wendell Ryce & Son	ADDRESS 3216

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53165

CERTIFICATE OF DEATH.

28 D 53165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Riggins

(a) RESIDENCE. No. 929 Franklin Road St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Riggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Daisy Zack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records
(Address) M.T.H.

15 FILED APR 24 1921 ROBERT I. KRAJTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 18, 1921, to April 22, 1921, that I last saw him alive on April 22, 1921, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous peritonitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. Hinsey, M. D.

4-22-21. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Celia Sun	April 26 1921
20 UNDERTAKER	ADDRESS 916
Daniel Easter	Ca ae

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122 D 53166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View, 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Day

(a) RESIDENCE. No. 402 Myrtle Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis, (State or country) Maryland

PARENTS

10 NAME OF FATHER Joe Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed APR 24 1921 ROBERT J. KRAUSE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1921, to April 21, 1921, that I last saw h.. alive on April 21, 1921, and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Nyles- Nephrosis-

? (duration) : yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. A. Holden, M. D.

4/22/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 24 1921
20 UNDERTAKER Denis Eagan	ADDRESS 9 E Cem a ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53167

CERTIFICATE OF DEATH.

D 53167

REGISTERED NO. 14 / 20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay Vista. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Davis

(a) RESIDENCE. No. 1725 Bolton St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Plumber Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Lucinda Tierce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records,
(Address): New City Hospital.

15 FILED APR 24 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1921, to April 22, 1921, that I last saw her alive on April 22, 1921, and that death occurred, on the date stated above, at 2:05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertension.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) [illegible] M. D.

(Address) New City Hospital. 4/23/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn bur	April 25 '21
20 UNDERTAKER	ADDRESS 916
Daniel Eyton	Pa ave

Burial should be certified to in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53168

14120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Sims

(a) RESIDENCE. NO. 1403 Argyle Ave ST., WARD.

(Usual place of abode) Unknown (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) New City Hospital

15 FILED APR 24 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1921, to April 21, 1921, that I last saw her alive on April 20, 1921, and that death occurred, on the date stated above, at 1:45 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. A. Holden, M. D.

4/21/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Apr. 26 21
20 UNDERTAKER Samuel Newbery	ADDRESS 578 W Baltimore

Should be stated EXACTLY. THOSE WHO ARE mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53169

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53169

CERTIFICATE OF DEATH.

8-091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 N Caroline ST.: 7 WARD)

2-FULL NAME Charles Richard Rosedon

(a) RESIDENCE. No. 613 N. Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced (write the word)
Male	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chield

6 DATE OF BIRTH (month, day, and year) Aug 19 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Born in Balt City

PARENTS

10 NAME OF FATHER Henry E Rosedon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germaker

12 MAIDEN NAME OF MOTHER Julia Beard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mother Julia Rosedon

(Address) 613 N Caroline St

15 Filed APR 24 1921 Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-22-1921

17 I HEREBY CERTIFY, That I attended deceased from 3-21-1920, to 4-22-1921, that I last saw h~~im~~ alive on 4-21-1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? his home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W H Cargill, M. D.

4-21-, 1921 (Address) 611 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery

DATE OF BURIAL April 24 1921

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates. of OCCUPA-

D 53170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53170

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1739 Myrtle Av ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Denis

(Residence in Baltimore: No. 1739 Myrtle Ave. St.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colred	married

6-DATE OF BIRTH, June, 1897
(Month) (Day) (Year)

7-AGE, 24 yrs. mos. ds.

If LESS than 1 day, hrs. or mln.:

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coloured Odd
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9-BIRTHPLACE, (State or Country), Balto. Md,

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Dennis

(Address) 1303 Prestman Ave

15- APR 24 1921 ROBERT J. KRAUTER

Filed ....., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dyspnea Heart disease

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) J. H. Kennedy M. D.
(Coroner.)

April 23, 1921 (Address) 2802 Eutaw Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, APR 25 1921, 19...

20-UNDERTAKER ADDRESS JAMES H. DENNIS 1303 PRESTMAN ST.

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53171

CERTIFICATE OF DEATH.

D 53171

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1539 Light ST.: 24 (WARD)

2-FULL NAME John Williamson

(a) RESIDENCE. No. 1539 Light ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Williamson

6 DATE OF BIRTH (month, day, and year) Nov 22 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gasoline Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Launch 030

(c) Name of employer Arundel Corporation

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Williamson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Pauline Sonnadstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Pauline Williamson
(Address) 1539 Light

15 Filed APR 24 1921

ROBERT J. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 15, 1921, to Apr 21, 1921, that I last saw him alive on Apr 23, 1921, and that death occurred, on the date stated above, at 2-2-a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) anemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Wm E Siffer, M. D.

4/24, 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 27 1921
20 UNDERTAKER	ADDRESS 502
Williams Cook	E North Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

U.S.A.

COPY

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53172

CERTIFICATE OF DEATH.

28 D 53172

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 210 N. Washington ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy A Robel

(Residence in Baltimore: No. 210 N. Washington St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Feb 8, 1895
(Month) (Day) (Year)

7-AGE, 26 yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Bassehart

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mattie —

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mattie Bassehart

(Address) 210 N. Washington st

15- APR 24 1921 ROBERT J KRAUTER
Filed....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1921, to April 22 1921, that I saw h[er] alive on April 22 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. ds.

(Signed) William H. Davis M. D.

4/23/21, 191... (Address) 801 N. Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cemetery DATE OF BURIAL, April 25, 1921

20-UNDERTAKER Henry C Lutz ADDRESS 1007 N. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Van Landingham

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53173

14 A 53173

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Van Landingham

(a) RESIDENCE. NO. 3rd Ave & 67th St. Fairfield WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced (or) WIFE of Logan Van Landingham Same address

6 DATE OF BIRTH (month, day, and year) Feb. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed APR 24 1921 ROBERT I. GRAUER Registrar Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from April 8-21, 19.., to April 21, 1921, that I last saw her alive on April 21, 1921, and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH* was as follows:

Uremia

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. 4 mos. ds.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes Blood chemistry & Pathological findings

What test confirmed diagnosis?

(Signed) Edward C. Davidson M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch	Apr 24 1921
20 UNDERTAKER John W. Toadvine	ADDRESS 142 Ursula St

MATTERS ENTERED IN CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53174

CERTIFICATE OF DEATH.

91 D 53174

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 Herring Court ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reuben Sparks

(a) RESIDENCE. No. 227 Herring Court St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4-1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Ruben Sparks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Edna Drake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Ruben Sparks 227 Herring Ct

15 Filed APR 24 1921 ROBERT P. [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-20 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-18-1920, to 4-20-1921, that I last saw h[illegible] alive on 4-20-1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Cargill, M. D.

4-21. 1921 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	Apr 24 1921
20 UNDERTAKER John H. Trading	ADDRESS 142 Wkill St

mation should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53175

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Levi

(a) RESIDENCE. No. Nursery + Child's Hospital STREET WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 22 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Morris Levi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Leah Levin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Leah Levin

(Address) 715 E north ave

15 Filed APR 24 1921 ROBERT J. KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1921

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1921, to April 23, 1921, that I last saw her alive on April 23, 1921, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Congenital syphilis

(duration) 1 yrs. 6 mos. 1 ds.

18 Where was disease contracted if not at place of death? at Nursery + Child's Hospital

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture, positive

(Signed) H. MacGowan, M. D.

4/23 1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 24 21
20 UNDERTAKER George J. Smith	ADDRESS 1000 W. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53176 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53176

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 141 N. Luzerne ave ST.: 6 WARD)

2-FULL NAME Catherine B. Wingate

(a) RESIDENCE. No. 141 N. Luzerne ave, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Samuel B. Wingate

6 DATE OF BIRTH (month, day, and year) May 6, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John N. Ely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles E. Wingate
(Address) 141 N. Luzerne ave.

15 Date APR 24 1921 ROBERT I. KRAUTH Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1921, to April 21, 1921, that I last saw h.. alive on 4 21 1921, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Bright's Kidney Disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Heavey M. D.

4/22 1921 (Address) 2600 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	Apr. 25 1921

20 UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 53177

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Robert St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Blay Fisher

(a) RESIDENCE. NO. 411 Robert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Fisher.

6 DATE OF BIRTH (month, day, and year) May 10 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Wife.

(b) General natore of Industry, business, or establishment in which employed (or employer) House Keeping

(c) Name of employer Self. Easton Md.

9 BIRTHPLACE (city or town) (State or country) Easton Md.

PARENTS

10 NAME OF FATHER Charles B. Blay.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Md

12 MAIDEN NAME OF MOTHER Charlotte Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton.

14 Informant William A. Fisher (Address) 411 Robert St.

15 Filed APR 24 1921 ROBERT J. KRAFFT Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1921

17 I HEREBY CERTIFY, That I attended deceased from April —, 1921, to April 23, 1921, that I last saw h.r alive on April 23, 1921, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Uterine - Carcinoma - Metastasis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of Mch. 14. 1914

Was there an autopsy? no.

What test confirmed diagnosis? Microscopical.

(Signed) William A. Wright, M. D.

April 24, 1921 (Address) 1209 Preston and St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 26 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Mall Av

N. B.—Items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53178

CERTIFICATE OF DEATH.

126 D 53178

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rogers Ave Nr Old Pimlico Road ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME R. Henry Holme

(Residence in Baltimore: No. Rogers Ave Nr Old Pimlico Rd St.; 31 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan. (Month) 17 (Day), 1846 (Year)

7-AGE, 75 yrs. 3 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Elk Dairy Co
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, Benj S. Holme

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER Elizabeth Dennis

13-BIRTHPLACE OF MOTHER (State or Country), N. J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Pauline W. Holme

(Address) Rogers Ave

15- APR 24 1921 ROBERT J. KRAUTER
Filed..... 191.....
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 22nd (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 15 1921, to April 22 1921, that I saw h.. in alive on April 21st 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Prostate Hypertrophy

(Duration) 20 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Renal insufficiency

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) Page Edmunds M. D.

4/23, 1921 (Address) 604 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Friends Cemetery — DATE OF BURIAL, April 25, 1921.

20-UNDERTAKER Chas. E. Franck — ADDRESS 802 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stock 6-0-19 H. P. Co. 1000 Bks.

D 53179

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53179

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital St.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kunigunda Buettner

(a) RESIDENCE. No. St Joseph's Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.

6 DATE OF BIRTH (month, day, and year) Jan 3rd 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer St Joseph Hospital

9 BIRTHPLACE (city or town)- (State or country) Germany.

PARENTS

10 NAME OF FATHER not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant N. Buettner (Address) St Joseph Hospital

15 Filed APR 24 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Apl. 14, 1921, to April 22, 1921, that I last saw her alive on April 22, 1921, and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Repeated Lumbar Punctures

(Signed) Charles A Donovan, M. D.

, 19 (Address) 6 E Reed St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemtry.	April 25 1921
20 UNDERTAKER Geo. J. Rueth	ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53180

CERTIFICATE OF DEATH.

D 53180

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. Bay View Hospital St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard C. Keyser

(a) RESIDENCE. No. 3323 Piedmont Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26, 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John H. Keyser

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Mebler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant City Hospital Records
(Address)

15 DATE RECEIVED APR 24 1921 BOYD E. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 2, 1920, to April 23, 1921, that I last saw h in alive on April 23, 1921, and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & serological tests.

(Signed) E. C. Medairy, M. D.

(Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	April 25, 1921
20 UNDERTAKER Birkler & Birkler	ADDRESS 1139 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53181

D 53181

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2926 Elliott ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Conroy

(a) RESIDENCE. No. 2926 Elliott ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Conroy

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER — Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Englemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Michael Conroy
(Address) 2926 Elliott St

15 Filed APR 24 1921 ROBERT P. BRUCE Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to April 22, 1921, that I last saw h.. alive on April 21, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Arterio - Sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. M. Moran, M. D.

4/24/21, 1921 (Address) 839 O. Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 4-25-1921

20 UNDERTAKER J. J. Moran

ADDRESS 300 E. Baltimore

All the information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53182

CERTIFICATE OF DEATH.

50

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 S. Chester ST.: 2 WARD)

2-FULL NAME Elizabeth Graham

(a) RESIDENCE. NO. 212 S. Chester ST., 2 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Graham

6 DATE OF BIRTH (month, day, and year) Sept 13-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER J. F. Schorr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Gribell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Ely. Graham (Address) 212 S. Chester St.

15 Filed APR 24 1921 ROBERT I. KRAUSE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15th, 1921, to April 21st, 1921, that I last saw her alive on April 21st, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ....yrs. ....mos. 7 ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Calet V. Athey, M. D.

, 19 (Address) 100 S. Potteron Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	4-25 1921

20 UNDERTAKER J. J. Moran ADDRESS 3000 E. Baltimore

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 53183

CERTIFICATE OF DEATH.

D 53183

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Vincents Infant asylum WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Olozenski

(a) RESIDENCE. NO. St. Vincents Infant asylum ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	whit	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 30 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo Olozenski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant S. W. Matthews
(Address) St. Vincents Infant asyl

15 Filed APR 24 1921 BOWEN & ABAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) april 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1921, to april 21, 1921, that I last saw him alive on april 21, 1921, and that death occurred, on the date stated above, at 10:40 pm.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Mal nutrition

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Geo Olozenski M. D.

Apr. 1921 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Apr 24 1921
20 UNDERTAKER	ADDRESS
Martin Fahey - Son	152 W North Ave

N. B.—WHILE PLAINLY WRITTEN, WITH UNFADING INK, THIS IS A LEGAL DOCUMENT. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53184

D 53184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Eutaw Place ST. 14 WARD) 79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minna Hochschild

(a) RESIDENCE. No. 1922 Eutaw Place ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 7 mos. — ds. How long in U. S., if of foreign birth? — yrs. 7 mos. — ds.

Germany

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Jacob Hochschild

6 DATE OF BIRTH (month, day, and year): April 8, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cologne Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Jacob Hochschild

(Address): 1922 Eutaw Place

15 Filed APR 24 1921

ROBERT S. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to April 23, 1921, that I last saw h.e.r. alive on April 23, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Stone in cystic duct - chr. cholecystitis

.....(duration) 1 yrs. 7 mos. ..... ds.

18 Where was disease contracted if not at place of death? Berlin Germany

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Charles G. Friedman, M. D.

, 19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem.

DATE OF BURIAL: 4/25/21

20 UNDERTAKER: David Sondheim

ADDRESS: 118 W. Mt. Royal Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53185

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 D 53185

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 3 WARD)

2-FULL NAME Mary Jarzynski

(a) RESIDENCE. NO. 1612 Eden Alley W ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? 27 yrs 0 mos. 0 ds
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Jarzynski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	32	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michal Wmerek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Walter Jarzynski
(Address) 1612 Eden Alley

15 Filed APR 24 1921 ROBERT F. RESNIK Registrar

Burial Permit 01874

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 19 1921, to Apr 22 1921, that I last saw her alive on Apr. 22 1921, and that death occurred, on the date stated above, at 11.30P m.

The CAUSE OF DEATH* was as follows:

General peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Apr. 22

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. McElwain, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Apr. 26 1921
UNDERTAKER Wm Faltkowski	ADDRESS Dista

be stated EXACTLY. PHYSICIANS should state
be properly classified. Exact statement of OCCUPA-
of certificates.

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be pr
TION is very important. See instructions on back of cer

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53186

CERTIFICATE OF DEATH.

28 D 53186

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 ST. Municipal Tuberculosis Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Szymanski

(a) RESIDENCE. No. 1122 Penton Ave., Curtis Bay (Pennington Ave.) ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanley Szymanski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed APR 24 1921 19 ROBERT J. KRUTZE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to April 22, 1921, that I last saw him alive on April 21, 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed dingnosis? T.B. in sputum, X-ray

(Signed) L. J. Kingsley, M. D.

4-22-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross R. C. Cem	Apr 25 1921

20 UNDERTAKER	ADDRESS
Wm Fallkowski	1118 East

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

53187

HEALTH DEPARTMENT—CITY OF BALTIMORE

53187 D 53187

CERTIFICATE OF DEATH.

REGISTERED NO. C 1579

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3706 Woodland Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeannette M Nelson

(Residence in Baltimore: No. 3706 Woodland Ave St.; 7 yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, October 11, 1835
(Month) (Day) (Year)

7-AGE, 85 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or estsblishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Valentine Adams

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sabyella Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel L Eugene

(Address) 3706 Woodland Ave

15- APR 25 1921 ROBERT I. RITTER
Filed....., 191... Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23rd, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from About Feby. 1st 1921, to April 23rd 1921, that I saw her alive on April 22nd 1921, and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis, Valvular cardiac lesion, with pleuritic & pericardial effusion & general oedema. (Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) The exhaustion & oedema (Duration) 10 yrs. 1 mos. X ds.

(Signed) A. H. Hagner M. D.

Apr. 23 1921 (Address) 2107 N. Eden.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. Frederick Md. DATE OF BURIAL, April 26, 1921

20-UNDERTAKER H Allen Fuller ADDRESS 3511 Springdale Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53188

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53188

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Warner ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Sims

(a) RESIDENCE. No. 910 Warner ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3.	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE - ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm Sims

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pittsburg.

12 MAIDEN NAME OF MOTHER Jamie Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Jamie Simms (Address) 910 Warner St.

15 Filed APR 25 1921 ROBERT J. BRAUER Registrar Burial Permit 01866

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 23- 1921.

17 I HEREBY CERTIFY, That I attended deceased from March 1 '21, to Apr. 23. 1921.

that I last saw her alive on Apr. 20. 1921.

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Interstitial peritonitis

(duration) yrs. 3- mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. C. Friedenwald M. D.

4/23/21 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	April 25 1921
20 UNDERTAKER	ADDRESS
C. H. & Brown & Son	108 W. Monty

Manner should be entirely supplied. Avoid abbreviations. Statements should be typewritten or carefully printed. Ink should be used. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

Muzieniez

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53189 ✓

D 53189

91

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 E Pratt St.: 3 Ward)

2-FULL NAME Ignatius Muzieniez

(a) RESIDENCE. No. 834 E Pratt St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? 17 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Ignatas Muzienis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant (Address) Vicka Muzienis 834 E Pratt St

15 APR 25 1921 ROBERT J. KRAUTH Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Apl 21, 1921, to Apl 23, 1921, that I last saw h— alive on Apl 23, 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Waldron, M. D.

April 26, 1921 (Address) 834 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	April 26 1921

20 UNDERTAKER — ADDRESS

John Grebliunas 445 S. Paca St.

Station should be carefully supplied. Answer each question so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53190 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53190

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 S. Eutaw ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Dixon

(a) RESIDENCE. No. 812 S Eutaw ST., WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Allen Dixon (deceased)

6 DATE OF BIRTH (month, day, and year): June 1851

7 AGE: Years 70 Months 9 Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): General Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Somerset Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Maggie Dixon

(Address) 812 S Eutaw St

15 Filed APR 25 1921 19.... ERNEST J KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/22/1921

17 I HEREBY CERTIFY, That I attended deceased from 1/24/1920, to 4/22/1921, that I last saw h... alive on 4/20/1921, and that death occurred, on the date stated above, at 11.30a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis (duration) about 6 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical - microscopical

(Signed) J. Guy Bowley, M. D.

4/23/1921 (Address) 906 D Sharp Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MD Cemetery Co. DATE OF BURIAL: 4/25/21

20 UNDERTAKER: Jno H Joadim ADDRESS: 142 W Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bull

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53191

CERTIFICATE OF DEATH.

61-001

D 53191

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3622 Cedar Ave. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Erma E Ball

(a) RESIDENCE. NO. 3622 Cedar Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): March 19, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Edward Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Inez Brushmiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Edward Ball

(Address) 3622 Cedar Ave

15 Filed APR 25 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24 1921

17 I HEREBY CERTIFY, That I attended deceased from April 22 1921, to April 24 1921, that I last saw h Or alive on April 24 1921, and that death occurred, on the date stated above, at 11:10 A m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro Spinal Meningitis (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Spinal Fundus

Did an operation precede death? No Date of Apl 24-21

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) Harry E. Alpini, M. D.

, 19 (Address) 3640 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	4/26 19

20 UNDERTAKER: Chenoweth Son ADDRESS Chestnut Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53192

CERTIFICATE OF DEATH.

151 D 53192

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 10 E Gittings St ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Johnson

(a) RESIDENCE. NO. 10 E Gittings ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. (Child)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Archer Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Elizabeth Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Archer Johnson (Address) 10 E Gittings St

15 Filed APR 25 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-1921

17

I HEREBY CERTIFY, That I attended deceased from Apr 8, 1921, to Apr 24, 19 ", that I last saw her alive on Apr 24, 19 ", and that death occurred, on the date stated above, at 5-05 P m.

The CAUSE OF DEATH* was as follows:

Congenital weakness due to prematur birth, about 8 mos gestation

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm E Sisson, M. D.

4/25 1921 (Address) 317 Taylor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	4-25 1921

20 UNDERTAKER E & B Harlee ADDRESS 115 E Wash St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53193

CERTIFICATE OF DEATH.

1920 D 53193

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2334 Vondenhorst Lane 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest C. Askauer

(a) RESIDENCE. NO. 2334 Vondenhorst Lane WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Matilda Steines.

6 DATE OF BIRTH (month, day, and year): Dec 16 - 1872

7 AGE: Years 48 Months 4 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Butcher.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry Askauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Theresa Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Matilda Askauer 2334 Vondenhorst Lane

15 Filed APR 25 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1921, to April 23rd 1921, that I last saw h~~e~~ alive on April 23rd 1921, and that death occurred, on the date stated above, at 12 45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) — yrs. — mos. 1/2 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wibberis Bruce M. D.

4/25 1921 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: Apr 26 1921

20 UNDERTAKER: J Henrig & Co — ADDRESS: 208 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53194

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53194

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH Hebrew aged Home

CITY OF BALTIMORE: (No. 5 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Seideman

(a) RESIDENCE. No. 111 Asquith St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) old age home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1411 E Balto St

15 Filed APR 25 1921 ROBERT E KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24th 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1920, to April 24, 1921, that I last saw h[illegible] alive on April 24 1921, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma
Chronic myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. E. McCutcheon, M. D.

, 19 (Address) 1420 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	4/25 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53195 D 53195

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West End Maternity REGISTERED No. C 19150

CITY OF BALTIMORE: (No. ..... ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Engell

(Residence in Baltimore: No. 1835 W Baltimore St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M.	White	Single

6-DATE OF BIRTH, April (Month) 23 (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Maryland.

PARENTS.

10-NAME OF FATHER, Charles Roy Engell

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Ilma Meade

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Engell (Charles)

(Address) 1935 W. Baltimore

15- Filed APR 25 1921 ROBERT J. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 23 1921, to April 23 1921, that I saw him alive on April 23 191..., and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Malformations

Spina Bifida

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Walter A. Cole M. D.

4/24/21, 192.. (Address) 541 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Apr. 25, 1921

20-UNDERTAKER C. F. McCormick — ADDRESS 1931 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53196 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53196

CERTIFICATE OF DEATH. 105

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 N. Dallas ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Boone

(a) RESIDENCE. No. 122 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Mar 30 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	X	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto - Md

PARENTS

10 NAME OF FATHER George Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sadie Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George Boone
(Address) 122 N. Dallas St.

15 Filed APR 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23-1921

17 I HEREBY CERTIFY, That I attended deceased from 3/7/, 1921, to 4/23, 1921, that I last saw him alive on 4/23/21, 19, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH was as follows: Gastro-enteritis

(duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Gastric catarrh

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto - Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jas C Robinson M. D.

(Address) 1536 E Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel entry	apr 26 1921
20 UNDERTAKER J Lord Hall	ADDRESS 1741 Div Ave

mation should be carefully supplied. Avoid abbreviations. Write plainly with ink. Do not use lead pencil. Physicians should state EXACTLY: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53197

CERTIFICATE OF DEATH.

150

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 Bond St.: 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Ruggiero

(a) RESIDENCE. No. 536 Bond St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/22/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Dominic Ruggiero

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Cocchia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rosario Ruggiero.
(Address) 536 Bond St

15 Date received APR 25 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/21 19

17 I HEREBY CERTIFY, That I attended deceased from 4/22/21, 19, to 4/24/21, 19, that I last saw h alive on 4/24/21, 19, and that death occurred, on the date stated above, at 8P m.

The CAUSE OF DEATH* was as follows:

Failure of Nervous Mech to Clear

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Lorini, M. D.

, 19 (Address) 211 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W Fairmount Cem	4/26/21
20 UNDERTAKER John J Gahagan	ADDRESS Light 1318

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-P-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53198

CERTIFICATE OF DEATH.

D 53198

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6th St Monel Park ST. 25 WARD) 151

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Allick Jr

(a) RESIDENCE. No. 6th St. Monel Park ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 4 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew J. Allick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Carrie S. D'Antony

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Carrie S. Allick

(Address) 6th St. Monel Park

15 APR 23 1921 ROBERT J. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Ap 24 1921

17 I HEREBY CERTIFY, That I attended deceased from Ap 9, 1921, to Ap 24, 1921, that I last saw him alive on Ap. 22, 1921, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Congenital Malnutrition

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

Apr 24, 1921 (Address) 1101 N. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 25 1921
20 UNDERTAKER James B Fyne	ADDRESS 1104 Madison Av

N. B.—PARTICULAR ATTENTION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53199 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53199

CERTIFICATE OF DEATH. REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Women's Hospital ST. 14 WARD)
2-FULL NAME Winifred R. Tredwell
(Hotel Belvedere) and No. Women's Hospital
(Residence in Baltimore: No. St.; yrs., mos. 7 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	married

6-DATE OF BIRTH, January 13, 1884
(Month) (Day) (Year)

7-AGE, 37 yrs. 3 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Cincinnati, Ohio

PARENTS.
10-NAME OF FATHER. Chas. A. L. Reed
11-BIRTHPLACE OF FATHER (State or Country). Wolf Lake, Indiana
12-MAIDEN NAME OF MOTHER Irene E. Daugherty
13-BIRTHPLACE OF MOTHER (State or Country). Illinois

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. Lawson Reed
(Address) Hotel Belvedere

15- Filed APR 25 1921, 191... ROBERT J. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 24, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

acute nephritis

(Duration) ....yrs. ....mos. 7 ds.
CONTRIBUTORY (Secondary) Broncho-pneumonia
(Duration) ....yrs. ....mos. 1 ds.
(Signed) J. J. Hennessy, M. D.
(Coroner.)
April 25 1921 (Address) 2802 E. Lemmon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death Women's Hosp. ....yrs. ....mos. 7 ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death? 727 St. Paul St.
Former or usual residence Frankfort, Ky.

19-PLACE OF BURIAL OR REMOVAL. Cincinnati, Ohio
DATE OF BURIAL. 4/25, 19....
20-UNDERTAKER Henry W. Mears & Son
ADDRESS 805 N. Calvert St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN making the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Via Penn. Railroad - Escort, C. Lawson Reed

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53200

CERTIFICATE OF DEATH.

D 53200

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 25 Druid Ave. ST.; Raspberry Alley WARD)

2-FULL NAME John A. Deppisch

(a) RESIDENCE. NO. 25 Druid Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Martha B. Deppisch

6 DATE OF BIRTH (month, day, and year) Oct. 18 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis F. Deppisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret C. Hintz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Martha B. Deppisch
(Address) 25 Druid Ave

15 Filed APR 25 1921 19 ..... Burial Permit ~~Issued~~ Registered

ROBERT A. GRAUER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 1911, to April 24 1921, that I last saw h.. alive on April 24, 1921, and that death occurred, on the date stated above, at 5 9 a.m.

The CAUSE OF DEATH* was as follows:

Anaemia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Symptoms

(Signed) ..... M. D.

1921 (Address) 4706 Hopkins Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Moby Redeemer	April 27 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1301 E. Eag.

N. B.—WRITE PLAINLY, with ink. AGE should be stated EXACTLY. PHYSICIAN'S Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION on back is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53201

CERTIFICATE OF DEATH.

D 53201

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Jefferson ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susian Hunter

(a) RESIDENCE. NO. 1310 Jefferson ST., WARD. Christfield Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced (or) WIFE of John Hunter

6 DATE OF BIRTH (month, day, and year) May [illegible] 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	11	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home Gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Accomac Co. Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Susian Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lee Sutton (daughter) (Address) 128 S. 4th St. Christfield Md

15 FILED APR 25 1921 ROBERT J. KRAUSE Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/18, 1921, to 4/25, 1921, that I last saw h.e.r alive on 4/25, 1921, and that death occurred, on the date stated above, at 6:15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinomas Uteri

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Exam.

(Signed) P. J. Young, M. D.

, 19 (Address) 1410 Jefferson St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Christfield Md.	Apr. 25 1921
20 UNDERTAKER	ADDRESS
Mrs J. H. Lockes.	1302 Jeffers

N. B.—WRITE PLAINLY, with ink. All items must be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53202 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53202

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 249 W. Hoffman St.: 11 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Waters

(Residence in Baltimore: No. 249 W. Hoffman St.: yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	Colored	single

6-DATE OF BIRTH. March 28, 1920
(Month) (Day) (Year)

7-AGE. 1 yrs. 1 mos. 22 ds. If LESS than 1 day, hrs. or. mln.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Philadelphia, Pa.

PARENTS.

10-NAME OF FATHER. Wm. Brady

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Flossie Waters

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Brady

(Address) 249 W. Hoffman St

15- APR 25 1921 ROBERT F. KRAUTER
Filed ....., 19.. Registrar
Burial Permit Issued

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 24, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) Jas. J. Hennessey M. D.
(Coroner.)

April 25, 1921 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Phila. Pa.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
W. M. Cubery Lane	April 27, 1921
20-UNDERTAKER Samuel J. Hennessey	ADDRESS 578 St. Paul St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53203

CERTIFICATE OF DEATH.

91

D 53203

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gabb

(a) RESIDENCE. NO. 2718 Eager West ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14 - 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57 yrs		9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor 080
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hospital Records
(Address)

15 Filed APR 25 1921 ROBERT J. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1920, to April 23, 1921, that I last saw him alive on April 23, 1921, and that death occurred, on the date stated above, at 7:45 A m.

The CAUSE OF DEATH* was as follows:

I Senility with depression

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Broncho-Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical tests

(Signed) H C Medairy, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	April 26 1921
20 UNDERTAKER	ADDRESS
Lilly and Zeiler	403 S Wolfe St.

ination should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53204

CERTIFICATE OF DEATH.

181

1-PLACE OF DEATH Curtis Bay Copper & Iron Works. REGISTERED No. C

CITY OF BALTIMORE (No. Curtis Bay. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J.George Doelfel.

(Residence in Baltimore: No. 2 nd.Ave & 19th.St-Canton. 25 St.; yrs., 3 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, January 2nd, 1896, (Month) (Day) 1 (Year)

7-AGE, 25 yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Chipper & caulker
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John G. Doelfel.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Elizabeth Heineman.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John G. Doelfel. (father)

(Address) 2nd. Ave. & 19th. St. Canton.

15- Filed APR 25 1921, 191.... ROBERT J. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22nd. 1921., (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & inqry (Inquest autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) & inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally electrocuted.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Theo Reinhardt M. D. (Coroner.)

Apl. 24..., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel Cem.	April 24 1921
20-UNDERTAKER Lilly & Zulu	ADDRESS 403 S. Wolfe St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53205

CERTIFICATE OF DEATH.

172 D 53205

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1248 S Sharp St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalena Tischer

(a) RESIDENCE. NO. 1248 S Sharp ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 19/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Fischer

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) Hungary

12 MAIDEN NAME OF MOTHER Julia Greisz

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Hungary

14 Informant Joseph Fischer
(Address) 1248 S. Sharp St.

15 Filed APR 25 1921 19 Registered

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1921

17 I HEREBY CERTIFY, That I attended deceased from April 14 1921, to April 24, 1921, that I last saw h— alive on April 23, 1921, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Pyelitis Pyelitis

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Phlegmon

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Microscopic

(Signed) Edw Grenkel, M. D.

4/24/1921 (Address) 817 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Balto	April 26 1921
20 UNDERTAKER C. W. Dill.	ADDRESS 3109 Fredk Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53206

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53206

CERTIFICATE OF DEATH.

122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Trimble

(a) RESIDENCE. No. 1935 Lemon St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland.

14 Informant: Hospital Records,
(Address): New City Hospital.

15 Filed APR 25 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23, 19 21

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1921, to April 23, 19 21
that I last saw h... alive on April 22, 19 21,
and that death occurred, on the date stated above, at 3:00 A. m.
The CAUSE OF DEATH* was as follows:

Pelvic Peritonitis
(From Bladder)
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Pyles - Nephrosis
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Mar. 24, 1921

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) F. A. Holden, M. D.

4/23/19 21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Apr 26, 1921
20 UNDERTAKER: John J. Gowan & Son	ADDRESS: 901 Hollins St.

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53207 D 53207

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 N. Linwood Ave. WARD) 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Flaherty

(a) RESIDENCE. No. 433 N. Linwood Ave. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Martin Ivors

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary ~~Ivors~~ Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Flaherty
(Address) H 33 N. Linwood

15 Filed APR 25 1921 Robert P. Harrison Registrar
(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1921, to Apr 22, 1921, that I last saw h[illegible] alive on Apr 22, 1921, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Fatal ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clin. Symptoms

(Signed) B.V. Kelly, M. D.

, 19 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross.	Apr 26 1921
20 UNDERTAKER John A. Moran	ADDRESS 3000 E. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53208

147668

D 53208

CERTIFICATE OF DEATH.

REGISTERED NO. 76

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns. Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve McNicholas

(a) RESIDENCE. No. 816 N. Caslen Pl ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Five yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Richard McNicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie Beker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

11 Informant (Address) Johns Hopkins Hospital Baltimore

15 Filed APR 25 1921, 19 Robert P. Harrison, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23- 1921

17

I HEREBY CERTIFY, That I attended deceased from April 20-, 1921, to April 23-, 1921, that I last saw her alive on April 23-, 1921, and that death occurred, on the date stated above, at 5 15 a. m.

The CAUSE OF DEATH* was as follows:

Otitis Media and Chronic Mastoiditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Brain Abscess

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

Apr 25, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Apr 26 1921
20 UNDERTAKER	ADDRESS
John A Moran	3000 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53209

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

D 53209

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 Mc Elderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Imogene Frey

(Residence in Baltimore: No. 1916 Mc Elderry St. Sta Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, Unknown, ... (Month) ..... (Day) ..... (Year)

7-AGE, about 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Frey

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Martha

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm F Frey

(Address) Ovorlea, Md.

15-

Filed ....., 191.....

Registrar.

Robert P. Harr[illegible]

Burial Permit [illegible]

APR 25 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 20 1921, to Apr 23 1921, that I saw her alive on Apr 23 1921, and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Frank J. Clyde M. D.

Apr 25, 1921 (Address) 2006 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Apr. 26, 1921.

20-UNDERTAKER John A. Moran

ADDRESS Wood & Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53210 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53210

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Cliftview Av. ~~St.~~; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Landon

(a) RESIDENCE. No. 1560 Cliftview Av. ~~St.~~ 8 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. 11 mos. 8 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis W. Landon

6 DATE OF BIRTH (month, day, and year) May 16 - 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ~~~~

(c) Name of employer ~~~~

9 BIRTHPLACE (city or town) (State or country) Somerset Co. Md.

PARENTS

10 NAME OF FATHER John Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Doughty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Chas. E. Ford (Address) 1500 Cliftview Av.

15 Filed APR 25 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 6, 1921, to Apr. 24, 1921, that I last saw her alive on April 24, 1921, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ~ yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Asthma

Uncertain (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~~~

Did an operation precede death? No Date of ~~~~

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby M. D.

Apr. 24, 1921 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairmount Somerset Co. Md.	4/27 1921
20 UNDERTAKER	ADDRESS
I. Fuo McCully	130 E. Fay

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53211 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53211

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2740 W. Mosher ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Corkran

(Residence in Baltimore: No. 2740 Mosher St. St.; 71 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Aug 26, 1849
(Month) (Day) (Year)

7-AGE, 71 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Corbin Amos Clark

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Fitzpatrick

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace E. Obrider

(Address) 2740 Mosher St

15-

Filed Apr 25 1921 Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 18 1921, to April 23rd 1921, that I saw her alive on April 23rd 1921, and that death occurred, on the date stated above, at 5:40 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) .....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Henry H. Kerr M. D.

April 24, 1921. (Address) 1302 Light

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, April 27, 1921

20-UNDERTAKER Robert Burke & Son

ADDRESS Calhoun & Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 Sanford Place ST., 14 WARD) 91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Vernon Ruppert

(a) RESIDENCE. No. 535 Sanford Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 7th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Ruppert

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Leona Hoffman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Louis Ruppert
(Address) 535 Sanford Place

15 Filed APR 26 1921 19 ROBERT F. KRAMER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1921, to April 24, 1921, that I last saw h.im alive on April 23, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas. Kirkley, M. D.

, 19 (Address) 4500 Main St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem. (Roslyn.)	Apr 26 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto. St.

mation should be carefully supplied. AGE should be stated EXACTLY. FRACTIONS should not be used.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53213 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53213

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 675 Sarah Ann ST.; 4 WARD)

2-FULL NAME Henry Fowlar

(a) RESIDENCE. No. 675 Sarah Ann ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1875-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Jamaica -

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Daniel Earley

(Address) 916 Ca ave

15 Filed APR 26 1921 ROBERT F KRAUSE Registrar

Burial Permit Oler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/16 1921 to 4/24 1921 that I last saw him alive on 4/23/21 and that death occurred, on the date stated above, at 1030 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Goldman M. D

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL April 26 1921

20 UNDERTAKER Daniel Earley

ADDRESS 916 Ca ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53214

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53214

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 800 N. Montford Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Columbus W. McCafferty

(a) RESIDENCE. NO. 800 N. Montford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of Lillie McCafferty

6 DATE OF BIRTH (month, day, and year) Dec 21 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Varnisher

(b) General nature of industry, business, or establishment in which employed (or employer) Wood Finisher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm McCafferty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lillie McCafferty

(Address) 800 N. Montford

15 Date APR 26 1921 ROBERT J. KLUTE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 1920, to April 24, 1921, that I last saw h-- alive on April 23rd 1921, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage, Hemiplegia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. B. Leigh, M. D.

April 24 1921 (Address) 830 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: Apl 27 1921

20 UNDERTAKER: Philip Henry

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53215

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53215

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2092 E. Carey ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda M. Hoover

(a) RESIDENCE. No. 2092 E. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 5, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md.

PARENTS

10 NAME OF FATHER Eli Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Elizabeth Hoover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md.

14 Informant Myrtle E. Hoover
(Address) 2092 E. Carey St

15 APR 26 1921 ROBERT I. CRAWFORD Registrar
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 24th 1920 19, to Apr 24th 1921, 19, that I last saw her alive on Apr 24th 1921, 19, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chr valvular disease

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. R. Lucas, M. D.

19 (Address) 619 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md	April 27 1921
20 UNDERTAKER George W. Smith	ADDRESS 1000 Fayette St

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53216 97

HEALTH DEPARTMENT—CITY OF BALTIMORE 28 D 53216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Michel

(a) RESIDENCE. No. 409 N. Stricker St. City. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Gainer (sister)

6 DATE OF BIRTH (month, day, and year) Aug. 5, 1852.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Theodore Michel (dead)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ellen Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Johns Hopkins Hospital. (Address) Records

15 FILED APR 26 1921 ROBERT J. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1921, to April 25, 1921, that I last saw him alive on April 25, 1921, and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH* was as follows:

Respiratory Failure
caused by sloughing of cervical vertebra causing pressure on spinal cord in region of respiratory center

(duration) 5 minutes

CONTRIBUTORY (Secondary) Cervical caries
Pulmonary tuberculosis
Intestinal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) H. H. Kurall M.D.

4-25, 1921 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Md.	April 27-21
20 UNDERTAKER	ADDRESS
W. W. Lukens & Son.	Viola & McCulloh

N. B.—WRITE PLAINLY. PHYSICIANS should state AGE should be carefully supplied. mation should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53217

CERTIFICATE OF DEATH

D 53217

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. X 1144

CITY OF BALTIMORE: (No. 1514 Division ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Captain William E. Eliason

(a) RESIDENCE. No. Baylor's Lane—Pikesville, Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. W. E. Eliason

6 DATE OF BIRTH (month, day, and year) Jan. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	3	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work President of Steamboat Company
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER James Eliason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Lea Hanson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Henry Eliason
(Address) 2728 N. Charles St.

15 Filed APR 26 1921 ROBERT I. CRAWFORD Registrar
Social Service Bldg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 22, 1921, to Apr. 25, 1921, that I last saw him alive on Apr. 25, 1921, and that death occurred, on the date stated above, at 9.05 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

Instantaneously
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation (Cholecystectomy)
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 4/22/21

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. Blackerby M. D.

4/25 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 28 1921

20 UNDERTAKER George J. Small ADDRESS 1000 W. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53218

CERTIFICATE OF DEATH.

D 53218

REGISTERED NO. 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 W. Baser ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie. E. Montgomery

(a) RESIDENCE. NO. 1019 W. Baser ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced (write the word)~~: Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Montgomery

6 DATE OF BIRTH (month, day, and year): Sept 6 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jacob Ledley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary A. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Hoffman

(Address): 1019 W. Baser St

15 Filed APR 26 1921

ROBERT J. FRAZIER Registrar

Burial Permit Oliet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 6, 1920, to April 23, 1921, that I last saw h.. alive on April 23, 1921, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia

(duration) 6 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edw Grantham M. D.

4/26 1921 (Address) 517 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N. S. National Cemetery	April 27 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2178 Pa

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Gries

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53219

CERTIFICATE OF DEATH.

28 D 53219

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 S. Bentalou ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Gries

(a) RESIDENCE. No. 515 Bentalou ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Wht. | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Gries

6 DATE OF BIRTH (month, day, and year): Jan 16, 1897

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rose Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frederick Gries
(Address): 517 S. Bentalou St

15 Filed APR 26 1921 ROBERT J. KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24 19 21

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 19 21, to April 24, 19 21, that I last saw her alive on June 22, 19 21, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Boyd, M. D.

(Address) 602 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Apr 27 1921
20 UNDERTAKER	ADDRESS
Geo. L. Schnaat & Bro	2101 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53220

REGISTERED No. C 19159

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1407 Ramsey St.; WARD) 19

2-FULL NAME Wm. M. Ranch

(Residence in Baltimore: No. 1407 Ramsey. St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 7 (Day), 1884 (Year)

7-AGE, 37 yrs. 1 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Motorman
(b) General nature of industry, business, or establishment in which employed (or employer)..... U. R. R. Co

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Lawrence Ranch

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Annie Hett

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola M. Ranch.

(Address) 1407 Ramsay St

15-

Filed APR 26 1921, 191.... ROBERT F. KRAUTER Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun Shot wound Suicide

(Duration) yrs. mos. 1 hrs.

CONTRIBUTORY (Secondary) Shock;

(Duration) yrs. mos. ds.

(Signed) Geo E Blade M. D.

(Coroner)

4/24/21 (Address) 43 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Apr. 27 1921

20-UNDERTAKER Geo. E. Lohmeyer & Bro

ADDRESS 1101 Eutaw Ave

D 53221

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 53221

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1019 Patapsco St.; WARD) 23

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman J. Brown

(Residence in Baltimore: No. 1019 Patapsco St. St.; yrs. 11 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
male	white	single

6-DATE OF BIRTH May (Month) 17 (Day), 1920 (Year)

7-AGE yrs. 11 mos. 8 ds. | If LESS than 1 day, ..hrs. or —min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: not any
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country) Baltimore Md

PARENTS

10-NAME OF FATHER Henry Brown

11-BIRTHPLACE OF FATHER (State or country) Baltimore Md

12-MAIDEN NAME OF MOTHER Alice Trush

13-BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Brown

(Address) 1019 Patapsco St.

15 ROBERT J. KRAUTER REGISTRAR

Filed APR 26 1921 Burial Permit

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April (Month) 25 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to April 25 1921, that I saw him alive on April 24, 1921, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 14 ds

Contributory (SECONDARY) Rickets

(Duration) yrs. 3 mos. ds.

(Signed) G. H. Burton M. D.

4/25, 1921 (Address) 301 E. Cross St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..yrs. ..mos. ..ds. | In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cem.

DATE OF BURIAL: 4/26, 1921

20-UNDERTAKER: F. C. Turner & Son

ADDRESS: 763 Hanover St

Boring

D 53222

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 53222

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 726 W. North Ave ST. 13 WARD)

2-FULL NAME John Henry Boring

(a) RESIDENCE. (No. 726 W. North Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Boring

6 DATE OF BIRTH (month, day, and year) Dec 11, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tobacco Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) — 045

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Geo. Boring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary C. Koppelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Ruth Boring

(Address) 726 W North Ave

15 Filed APR 26 1921 [redacted] Registrar

Burial Permit Oleph

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1921, to April 26, 1921, that I last saw him alive on April 25, 1921, and that death occurred, on the date stated above, at 4 A.M. p.m.

The CAUSE OF DEATH* was as follows:

Acute dilation of heart; myocarditis

over 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Manus Lazenby, M. D.

, 19 (Address) 1 E W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	4/29/21
20 UNDERTAKER	ADDRESS
F. A. Frame & Son	703 Fairmount

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

JOHNSON

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53223

D 53223

CERTIFICATE OF DEATH.

REGISTERED NO. C 1192

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 Monroe ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Johnson

(Residence in Baltimore: No. 528 Monroe St.; 37 yrs., 3 mos. \ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan. 24, 1884 (Month) (Day) (Year)

7-AGE, 37 yrs. 3 mos. \ ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Waiter
(b) General nature of industry, business, or establishment in which employed (or employer). Private Family

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William A. Johnson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Carroll

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William A. Johnson (Father)

(Address) 823 W. Franklin St.

15 APR 26 1921 ROBERT P. KRAUTER

Filed....., 191... Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 24, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23 1921, to April 24 1921, that I saw h[illegible] alive on April 24 1921, and that death occurred, on the date stated above, at 10.14 p.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ....yrs....mos. 2d. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(Duration) ....yrs....mos.... ds.

(Signed) Thos. Hemmeter M. D.

April 26, 1921 (Address) 501 Hamburg St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, April 27 1921

20-UNDERTAKER Jos. M. Johnson

ADDRESS 1234 Eutaw St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 53224 HEALTH DEPARTMENT—CITY OF BALTIMORE VD 53224

CERTIFICATE OF DEATH. 28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 4 WARD)

2-FULL NAME Leslie Johnson

(a) RESIDENCE. NO. 651 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 12, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant E. D. Shreve
(Address)

15 Filed APR 26 1921 ROBERT E. LEAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1921

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1921, to April 20, 1921, that I last saw him alive on April 20, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 3 mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination ? Tuberculosis

(Signed) William H. Schwartz, M. D.

4/21, 1921 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
ERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER
Commissioner Health.

ADDRESS APR 26 1921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53225 ✓ D 53225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 715 So. Bond ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MICHAEL HARCHUT,

(a) RESIDENCE. NO. 715 So. Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? 33 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Harchut,

6 DATE OF BIRTH (month, day, and year) September --- 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laylaborer, 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Powiat, Ropczyce,
(State or country) Poland,

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town) Powiat,
(State or country) Ropczyce, Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) Powiat,
(State or country) Ropczyce, Poland,

14 Informant Mary Harchut, (Wife)
(Address) # 715 So. Bond Street

15 FILED APR 26 1921 ROBERT F. BRUDEN Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25 19.... to April 25th 1921, that I last saw h-- alive on ....., 19 21, and that death occurred, on the date stated above, at 10.40A m.

The CAUSE OF DEATH* was as follows:

Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L Wiesner, M. D.

4-27-21 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus, Cem.,	April 28 1921.
20 UNDERTAKER M. J. Sadowski.	ADDRESS 705 S. Ann

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53226

CERTIFICATE OF DEATH.

29 D 53226

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugstav A. Pohl

(a) RESIDENCE. NO. 18 n Collington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker.

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dulls Md

PARENTS

10 NAME OF FATHER Georg Pohl.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dulls Md

14 Informant Mrs Idw Kolb s/p

(Address) 1403 N Central Ave

APR 26 1921

ROBT. J. TRAUTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1921

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1921, to April 24, 1921, that I last saw him alive on April 24, 1921 and that death occurred, on the date stated above, at 10 33 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. C. Marquez, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dulls Cemetery	April 27 1921

20 UNDERTAKER E J Fanning & Son ADDRESS 1538 E Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53227.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 53227

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2017 Etting ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Young

(a) RESIDENCE. No. 2017 Etting ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 6 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 2017 Etting Balto (State or country) Md

PARENTS

10 NAME OF FATHER Chas. E. Young

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Zenora Beal

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Chas. E. Young
(Address) 2017 Etting

15 Filed APR 26 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25/21 19

17 I HEREBY CERTIFY, That I attended deceased from 4/6 19 21, to 4/25 19 21,
that I last saw he alive on 4/25 19 21,
and that death occurred, on the date stated above, at 3:50 p.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Dysentery

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2017 Etting

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Burk Carter M. D.

, 19 (Address) 2/3 D St. N

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr. 26 1921
20 UNDERTAKER	ADDRESS
Edw. Ruggold	1463 Carey

mation should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Moser.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53228

CERTIFICATE OF DEATH.

109 D 53228

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 402 N. Gilmor ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Moser

(a) RESIDENCE. No. 402 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Moser

6 DATE OF BIRTH (month, day, and year) May 1841

7 AGE 80 Years | Months 1 | Days 19 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gestis Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Feldgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant H. W. Mason (Address) 504 Hayward ave

15 Filed APR 26 1921, 19 ROBERT I. KRAUTH Registrar

Burial Permit Oleck

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1921

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1921, to April 25, 1921, that I last saw h.. alive on April 25, 1921, and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Obstructed bowels
Cause unknown

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Old age

(duration) 80 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date, of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. G. Bearce, M. D.

(Address) 1600 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL April 28 1921

20 UNDERTAKER Wm L. Miller — ADDRESS 2334 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53229 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53229

CERTIFICATE OF DEATH.

REGISTERED No. C 12

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2271 N Bolton St. ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Carson

(Residence in Baltimore: No. 2271 N. Bolton St. St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 9 (Day), 1836 (Year)

7-AGE, 84 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Benjamin Elliott

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Mary Sterne

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Harden

(Address) 2271 Bolton St

15-

Filed....., 1921 Robert P. Harrison, M.D.

Registrar.

R 26 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Bruises

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. E. Braddell M. D.

4/25/21 (Coroner.) 1921 (Address) 143 N. Bway

*State (1) DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	April 27, 1921
20-UNDERTAKER	ADDRESS
Jno Curley	502 E Pratt

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

14-7198 D 53230

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 53230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.:) 7 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Judson

(a) RESIDENCE. No. 10 McDonough St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Judson

6 DATE OF BIRTH (month, day, and year) July 20-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER J. Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

~~Robert P. Harrison,~~

15 Filed ... 19 ... Registrar

APR 26 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 - 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30 - 1921 to April 24 - 1921 that I last saw h- alive on April 24 - 1921 and that death occurred, on the date stated above, at 4 50 p.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(duration) about 4 mos. ... ds.

CONTRIBUTORY (Secondary) Septicaemia terminal

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? at her home.

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Gross examination of tissue

(Signed) J. T. Mason, M. D.

4-25-21 . 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	April 27 1921
20 UNDERTAKER Pinkert & Pinkert	ADDRESS 1739 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53231

CERTIFICATE OF DEATH.

126

D 53231

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospt. WARD 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Daum

(a) RESIDENCE. No. 931 N. Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Pauline Daum

6 DATE OF BIRTH (month, day, and year) Oct 4, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter, House

(b) General nature of industry, business, or establishment in which employed (or employer): 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Pauline Daum

(Address) 931 N. Eden st

15 Filed ..... 19..... Robert P. Harrison, Registrar

PR 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1921

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1920 to April 25, 1921, that I last saw h/m alive on April 25, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate with retention of urine

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Residence

Did an operation precede death? Yes Date of April 23, 20

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M. L. Hopkins, M. D.

, 19 (Address) Maryland Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity — DATE OF BURIAL: April 28 1921

20 UNDERTAKER: Jurkat & Jurkat — ADDRESS: 1739 Eager

Should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may may be found on back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53232

CERTIFICATE OF DEATH.

26 D 53232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 Rutland ST.; 7 WARD)

REGISTERED NO.:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William K. Pridgeon

(a) RESIDENCE. No. 836 Rutland ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Alice T. Pridgeon

6 DATE OF BIRTH (month, day, and year) April 5, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59		21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm R. Pridgeon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Liverpool

12 MAIDEN NAME OF MOTHER Susanna Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Alice T. Pridgeon
(Address) 836 Rutland ave

15 Filed APR 26 1921

16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1921

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1921, to April 26, 1921, that I last saw him alive on April 25, 1921, and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about
(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

, 19 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	April 29 1921
20 UNDERTAKER	ADDRESS
Burkert & Pickler	1739 Eager

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53233

CERTIFICATE OF DEATH.

D 53233

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Cording ave ST. 27th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Cording

(a) RESIDENCE. No. 506 Cording Ave ST. 27 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John H. Cording

6 DATE OF BIRTH (month, day, and year) March 25, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) German

PARENTS

10 NAME OF FATHER John Fehler

11 BIRTHPLACE OF FATHER (city or town) (State or country) German

12 MAIDEN NAME OF MOTHER Rothenburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Greif

(Address) 3501 E. Eliot st

15 Filed Robert P. Harrison, Registrar

APR 26 1921

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1920, to Apl 24, 1921, that I last saw her alive on Apl 24, 1921, and that death occurred, on the date stated above, at 4.35 A m.

The CAUSE OF DEATH* was as follows: Mitral stenosis

for

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) attack of Influenza in Oct 1920 (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Hoofnagle M. D.

. 19 (Address) 5835 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 27 1921
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1759 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53234

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1579 D 53234

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Queen Anne Road ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Forbes

(a) RESIDENCE. No. 9 Queen Anne Road ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Forbes

6 DATE OF BIRTH (month, day, and year): Dec. 30, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Elkton, Maryland

PARENTS

10 NAME OF FATHER: John Garrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wilmington, Delaware

12 MAIDEN NAME OF MOTHER: Elizabeth Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Elkton, Maryland

14 Informant: James T. O'Neill

(Address): 9 Queen Anne Road

15 Filed ..... 19.. Robert P. Harrison Registrar

PR 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4 - 24 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-10, 1921, to 4-24, 1921, that I last saw her alive on 4-24, 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) N K yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Aaching L. Fehsenfeld M. D.

19 (Address) 2806 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/27, 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

14776 D 53235

HEALTH DEPARTMENT—CITY OF BALTIMORE D 53235

CERTIFICATE OF DEATH.

14

REGISTERED NO.....

1-PLACE OF DEATH

D 53235

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abner Hooper

(a) RESIDENCE. No. 1527 E Fayette St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8 - 1920

7 AGE — Years: — Months: 10 — Days: 7 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Willie Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Amanda Colbus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Johns Hopkins Hospital Records.

15 Filed APR 26 1921 Robert P. Harris Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 - 1921

17

I HEREBY CERTIFY, That I attended deceased from April 25 - 1921. to April 25 - 1921.

that I last saw h.. alive on April 25 - 1921.

and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Dysentery Purulent / Meningitis (Etiology Undetermined)

(duration) ? yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Horton Caspares, M. D.

4-26, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cmty

DATE OF BURIAL: April 27 1921

20 UNDERTAKER: George H. Holland

ADDRESS: 1631 Druid Hill Ave

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53236 ✓ D 53236

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. New City Hospital, Bay View 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Burton

(a) RESIDENCE. No. 614 Lennox St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed APR 26 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1921 to April 25, 1921
that I last saw her alive on April 25, 1921
and that death occurred, on the date stated above, at 1:45 P.m.
The CAUSE OF DEATH* was as follows:

Arterio - sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) R. E. Harriman, M. D.

4/25/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Shop's Id Cemetery	April 27 1921
20 UNDERTAKER Fos Joerdens Son	ADDRESS 2173 E. Pra

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53237

HEALTH DEPARTMENT—CITY OF BALTIMORE

41 D 53237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Brown

(a) RESIDENCE. NO. 2021 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
RUSBAND of
(or) WIFE of George Brown.

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer) 680

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER John H. Wythe

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known
(State or country)

14 Informant Julia W. Savoy
(Address) 1727 McCulloh St

15 Filed ....., 19.... Robert T. Harrison, Registrar

APR 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1921, to April 26, 1921, that I last saw h.e alive on April 25, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Surgical Shock 2 hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Abdom. Sepsis
(duration) 13 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 4/26/21

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. S. McCard, M. D.

4/26 1921 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester Point Va	April 29 1921
20 UNDERTAKER	ADDRESS
Jno Henry Smith	313 Argyle Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Intestines

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53238

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Patapsco ST. 23 WARD)

2-FULL NAME Sophie Boyce

(a) RESIDENCE. NO. 1602 Patapsco ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Female	white	Married

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of James Boyce

6 DATE OF BIRTH (month, day, and year) Feb 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary V. Esser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Boyce
(Address) 1602 Patapsco St.

15 Filed APR 26 1921

16 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15 1921, to April 24 1921, that I last saw h.. alive on April 24, 1921, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No State of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Harrison, M. D.

4/26, 1921 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Apr. 26 1921
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53239

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 W. Lafayette Ave. ST.; 11 WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morton Schaeffer

(a) RESIDENCE. No. 222 W. Lafayette Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Murphy

6 DATE OF BIRTH (month, day, and year) Dec. 11, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward K. Schaeffer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Morton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Eliza Murphy Schaeffer
(Address) 222 W. Lafayette Avenue

15 APR 27 1921 ROBERT J. BRUTE Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to April 25, 1921, that I last saw h.... alive on April 24, 1921, and that death occurred, on the date stated above, at 5 10 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James P. Hutchinson, M. D.

April 26, 1921 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	4/27 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53240

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 401 Glen Edward Ave 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Harry M Stansbury

(Residence in Baltimore: No. 401 Glen Edward Ave 8 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Aug (Month) ..... 10 (Day), 1879 (Year)

7-AGE, 41 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Teamster
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER. Joseph A Stansbury

11-BIRTHPLACE OF FATHER (State or Country) Carroll Co Md

12-MAIDEN NAME OF MOTHER. Mary Stonesifer

13-BIRTHPLACE OF MOTHER (State or Country) Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachel Stansbury

(Address) 401 Glen Edward Ave

15-

Filed APR 27 1921 ROBERT J KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 25 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Coroner.)

April 26, 1921. (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Manchester Cemetery Co. DATE OF BURIAL, April 27 1921

20-UNDERTAKER. W. E. Cockey & Son ADDRESS 1520 N Charles St

Sylvia V Merchant

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53241

53241

CERTIFICATE OF DEATH.

REGISTERED No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~Sylvia V Merchant~~ 804 W Lexington St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sylvia V Marchant

(Residence in Baltimore: No. 804 W Lexington St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan (Month) 29 (Day), 1878 (Year)

7-AGE, 43 yrs. 2 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt md

PARENTS.

10-NAME OF FATHER, James Buhl

11-BIRTHPLACE OF FATHER (State or Country) Balt Co md

12-MAIDEN NAME OF MOTHER, C. Turnbaugh

13-BIRTHPLACE OF MOTHER (State or Country), Balt Co md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lula Hugel

(Address) 1432 Orleans St

15-

Filed APR 27 192 191... ROBERT J. KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 25 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ....find that said deceased came to ~~topsy or~~ her death inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular Heart disease

Duration) Don't know yrs. mos. ds.

Nursing a fall 3 months

CONTRIBUTORY (Secondary) Don't know

(Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D.
(Coroner.)

4-26-, 1924. (Address) 117 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, April 28, 1924

20-UNDERTAKER Wm Cook

ADDRESS 582 E Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53242

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 53242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 W 23 St ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth E Peyton

(a) RESIDENCE. No. 411 W 23d ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jos. E. B. Peyton

6 DATE OF BIRTH (month, day, and year): Aug 11 1853

7 AGE: Years 68 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: John Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Jos E Peyton

(Address): 411 W 23d St

15 Filed APR 27 1921 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl 27 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25 1921, to April 27 1921, that I last saw her alive on April 26 1921, and that death occurred, on the date stated above, at one a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (Cause)

Left Hemiplegia

(duration) 1 yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(duration) about 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure Test - Clinical Evidence

(Signed) H. Kelly, M. D.

4/27, 1921 (Address) 3849 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harpers Ferry West Va

DATE OF BURIAL: Apl 30 1921

20 UNDERTAKER: Thenowerth Son

ADDRESS: Chestnut St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53243

D 53243

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Gerard Av ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Foreman

(a) RESIDENCE. NO. 2005 Gerard ST. 13 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4/24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-26-21

7 AGE — Years — Months — Days — If LESS than 1 day, 4 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt Md
(State or country)

PARENTS

10 NAME OF FATHER Leonard Foreman

11 BIRTHPLACE OF FATHER (city or town) Balt Md
(State or country)

12 MAIDEN NAME OF MOTHER Mc Mullen

13 BIRTHPLACE OF MOTHER (city or town) Balt Md
(State or country)

14 Informant Leonard Foreman
(Address) 2005 Gerard

15 Filed APR 27 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-26, 1921, to 4-26, 1921, that I last saw h[illegible] alive on 4-26 1921, and that death occurred, on the date stated above, at 7 39 m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cyanosis

(Signed) C F Carbaugh, M. D.

4-26, 1921 (Address) 320 Rolling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Apl 26 1921

20 UNDERTAKER Chenoweth Bros ADDRESS Baltimore Co

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53244

CERTIFICATE OF DEATH.

176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Wendler

(a) RESIDENCE. No. Baltimore Ave ST., WARD. Rossville Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS' mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth C Wendler

6 DATE OF BIRTH (month, day, and year) Jan 30 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

068

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Wendler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Nella Habrighorst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Adale Bates

(Address) 1903 N Rutter ave

15 APR 27 1921 ROBERT J. CARTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1921

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1921, to April 26, 1921, that I last saw him alive on April 26, 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate

over

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 20, 1921

Was there an autopsy? No.

What test confirmed diagnosis? Operation & examination

(Signed) Geo. L. Wiesing, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 28 1921
20 UNDERTAKER	ADDRESS
H M Routson	2258 N Rutter

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53245 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53245

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 16 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Nelson.

(a) RESIDENCE. No. 1144 N. Carrollton ave ST.. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8- 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Nelson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed APR 27 1921 ROBERT I. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1921

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1921, to April 26, 1921, that I last saw him alive on April 26, 1921, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

4-26, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 27 1921

20 UNDERTAKER Thomas E. Wright ADDRESS 1347 N Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.— Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2803 E Edmondson Ave D 53246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53246 1920 1-13 1503

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2010 Brunt St ST.: 14 WARD) 15-001 REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James R Johnson

(Residence in Baltimore: No. 2010 Brunt Street St.: yrs. 4yr mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, Aug ? (Month) (Day), 1903 (Year)

7-AGE, 17 yrs. 8 mos. ? ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Postal Dept
(b) General nature of industry, business, or establishment in which employed (or employer)..... Special Del

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Jacob Johnson

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Matilda Actwood

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Johnson

(Address) 2010 Brunt St

15-

Filed APR 27 1921 ROBERT J KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 25 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull (automobile accident)

(Duration) ..... yrs. ..... mos. ..... ds.

Instant death

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

April 26, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL April 28 1921
Mt Auburn	
20-UNDERTAKER Clarence E Wright	ADDRESS 364 W Cary

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53247

CERTIFICATE OF DEATH.

92 D 53247

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 949 N. Wolfe ST.; 7 WARD)

2-FULL NAME Adalinda Panzone

(Residence in Baltimore: No. 949 N. Wolfe st. St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Sept. (Month) 28 (Day), 1916 (Year)

7-AGE, 4 yrs. 6 mos. 28 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER Rocco Panzone

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Luisa De Nicola

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rocco Panzone

(Address) 949 N. Wolfe st.

15 APR 27 1921 BOARD OF HEALTH

Filed ....., 191.. Burial ... Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 25th (Month) (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from April 23 1921, to Apr. 25th 1921, that I saw her alive on Apr. 24 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Eks. Testa M. D.

....., 191... (Address) 710 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, 4/27/21 191...

20-UNDERTAKER Geo. J. Duffy ADDRESS 1935 Hanover

D 53248

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53248

CERTIFICATE OF DEATH.

175-004

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland General Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Alfred Cox

(Residence in Baltimore: No. 2207 Chelsea Terrace St.; yrs., 67 mos. 5 ds. 9)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
MALE	White	Widowed

6-DATE OF BIRTH, November (Month) 15 (Day), 1853 (Year)

7-AGE, 67 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Real-Estate.
(b) General nature of industry, business, or establishment in which employed (or employer)..... (self)

9-BIRTHPLACE, (State or Country), Somerset Co., Maryland.

PARENTS.

10-NAME OF FATHER, Elijah Cox

11-BIRTHPLACE OF FATHER (State or Country), Somerset Co., Md.

12-MAIDEN NAME OF MOTHER Caroline Muir.

13-BIRTHPLACE OF MOTHER (State or Country), Somerset Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Richard A. Cox, (son)

(Address) 2207 Chelsea Terrace, City.

15-Filed APR 27 1921 191.... ROBERT J. BRAUNE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull, Street car accident

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

April 25, 1921 (Address) 1802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State 67 yrs. 5 mos. 9 ds.

Where was disease contracted, if not at place of death?.....

Denison St., Walbrook, City.

Former or usual residence 2207 Chelsea Terrace

19-PLACE OF BURIAL OR REMOVAL, Upper Fairmount, Somerset Co. Maryland.

DATE OF BURIAL, 4/28/21

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Bks.

D 53249 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53249

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 Euclid Ave ST.: 27th WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah A. Cook

(Residence in Baltimore: No. 636 Euclid St.; 1 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Nov (Month) 11 (Day), 1855 (Year)

7-AGE, 62 yrs. 5 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country) Adam Co Pa

PARENTS.

10-NAME OF FATHER, Edward Adams

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Agnes Weaver

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Cook

(Address) 636 Euclid Ave

15-

Filed ..... 192.., 191.....

[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 25 1921, to April 25 1921, that I saw h[illegible] alive on April 25 1921, and that death occurred, on the date stated above, at 6[illegible] m.

The CAUSE OF DEATH* was as follows:

Uremic Coma, Hemorrhage from Stomach - No evidence of paralysis - 6 hours (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. T. Porter M. D.

4/26, 1921 (Address) 422 Rotandas

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Govans — DATE OF BURIAL, Apr 28, 1921

20-UNDERTAKER A. S. Marshall — ADDRESS 358 Gay St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53250

CERTIFICATE OF DEATH.

79 D 53250

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 304 Belvidere Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Ryan

(Residence in Baltimore: No. 304 Belvidere Ave ST.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ..., (Month) —— (Day) 1847 (Year)

7-AGE, 74 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gardener
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Margaret Howard

13-BIRTHPLACE OF MOTHER (State or Country): Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Ryan

(Address) 304 Belvidere Ave

15- APR 27 1921, 191..... ROBERT A. KRAUSE Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 26 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) John Hommes M. D. (Coroner.)

April 27 1921 (Address) 3622 Boston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters Cem	April 29 19....
20-UNDERTAKER	ADDRESS
Martin Tuley & Son	1529 N Walk Ave

D 53251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 70336

CERTIFICATE OF DEATH.

STILL 151

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2541 Fleet ST. 1 WARD)

2-FULL NAME Joseph Hawawieraski

(Residence in Baltimore: No. 2541 Fleet St St.; yrs. Life mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, April 26, 1921
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 1/2 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Walter Hawawieraski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Francis Hetmaneski

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Hetmaneski

(Address) 2541 Fleet St

15- APR 27 1921 Filed....., 191.....

ROBERT J. KRAUSE Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
Medicale (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

congenital debility

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Henry Ryan M. D.
(Coroner.)

4/26, 191. (Address) 1804 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem

DATE OF BURIAL, April 27, 1921

20-UNDERTAKER Stephen L Fralkowski

ADDRESS 1000 Kenwood Ave

D. Dallas Washington

D 53252 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Station W. B. & A. ST.: Park. Ave. WARD) 29

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME P. D. Washington

(Residence in Baltimore: No. Washington D.C. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day), 1860 (Year)

7-AGE, 61 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Saloon Keeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Wm Washington

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Eliz. Ivorde

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Washington

(Address) Washington D.C.

15-Filed APR 27 1921 191.... ROBERT J. KRAUTH Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Apr. 27, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. Hy. Heart

Duration ..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Geo. L. Wiley M. D. (Coroner)

Apr. 27., 1921 (Address) 1629 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Washington D.C.

19-PLACE OF BURIAL OR REMOVAL, Washington D.C. DATE OF BURIAL, Apr. 27, 1921.

20-UNDERTAKER Arnold L. Kennedy ADDRESS 378 N. Eddy St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53253

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel E. Brown.

(a) RESIDENCE. No. 307 E. 23rd St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

3a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Irene Brown. (wife).

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49.	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler. 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Brown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Johns Hopkins Hospital (Address) Baltimore

15 Filed APR 27 1921 ROBERT N. KRAUTZ Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1921, to April 26, 1921, that I last saw him alive on April 26, 1921, and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Pathological findings

(Signed) Edward C. Davidson M. D.

4-26, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md. DATE OF BURIAL Apr. 27 1921

20 UNDERTAKER Samuel Hensley ADDRESS 5778 W. Balto

MARGIN MUST NOT BE CUT—THIS IS A PERMANENT RECORD. ENTRIES should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may may be required. See instructions on back of certificates. TION is very important.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS

D 53254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53254

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 240 Bowers St. 18 WARD)
2-FULL NAME — Goodes.
(Residence in Baltimore: No. 240 Bowers St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

Dwight.

3-SEX, F

4-COLOR OR RACE, b

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Apr 25, 121
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.
If LESS than 1 day, 3 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Clarence Goodes.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Lee.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert P. Harrison,
(Signed) ....., 191.....
Deputy Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pernicious fever 6 mo —

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. C. Blade M. D.
(Coroner)

4/27/21 (Address) 436 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. | DATE OF BURIAL, ..., 19....

20-UNDERTAKER | ADDRESS

APR 27 1921

Commissioner Health.

APR 27 1921

WRITE PLAINLY, WITH UNFADING INK.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53255

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6-09

D 53255

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 E. Monument ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Cimino

(a) RESIDENCE. No. 1010 E. Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 13-1921

7 AGE 2 Years — Months 14 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Cimino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Rose Zaccari

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Charles Cimino
(Address) 1010 E. Monument St

15 Filed ..... Robert P. Harrison, Registrar

APR 27 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27- 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-27-21, 19..., to 4-27-21, 19..., that I last saw him alive on 4-26-21, 19..., and that death occurred, on the date stated above, at 4.20 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) measles

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Chas. Yeston, M. D.

. 19 (Address) 210 Pearl st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	April 28 1921
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Hanover

N. B.—WRITE PLAINLY. WITH UNFADING INK. All of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Kaschubbe)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53256

D 53256

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Kaschubbe.

(a) RESIDENCE. NO. Fusten & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Kaschubbe

6 DATE OF BIRTH (month, day, and year) Sept. 13-1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

Baltimore

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Francis Stolp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Sister Florence,
(Address) Fusten & Valley Sts.

15 Filed , 19 Registrar

APR 27 1921

Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1921

17 I HEREBY CERTIFY, That I attended deceased from November 19 to , 19 ,
that I last saw her alive on April 23 , 1921,
and that death occurred, on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:

Val. disease of heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warnecke, M. D.

April 27, 1921 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	April 29 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeile	403 S. Mo. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53257

CERTIFICATE OF DEATH.

29 D 53257

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1737 E. Fairmount Ave St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Cooper

(Residence in Baltimore: No. 1737 E. Fairmount Ave St.; 64 yrs.,.....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~ MARRIED, WIDOWED, ~~OR DIVORCED~~. (*Write* the word.) Married

6-DATE OF BIRTH, Sept (Month) 2 (Day), 1860 (Year)

7-AGE, 60 yrs. 7 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Produce dealer
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John A Cooper

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary A Seward

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabelle A. Cooper

(Address) 1737 E Fairmount Av

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 1920, to April 26, 1921, that I saw h[illegible] alive on April 25, 1921, and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilitation of heart

(Duration) yrs. 6 mos. ds.

(Signed) J. C. Trumbkin M. D.

April 26, 1921. (Address) 818 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, April 28, 1921.

20-UNDERTAKER J Kervig & Co

ADDRESS 2008 Adams

Spec.—6-8-19—H. P. Co.—1000 Bks.

D 53258 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53258

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2767 Alameda ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JULIA WAGNER,

(a) RESIDENCE. No. 2767 ALAMEDA AVENUE, ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced~~ (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hedwig Wagner

6 DATE OF BIRTH (month, day, and year) Mar 8-1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gr Lonne

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Steinmetz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lenhot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs A Mueller

(Address) 6801 N Eutaw

15 Filed ... 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25th 1921 to April 27th 1921, that I last saw her alive on April 25th 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Fitzgerald, M. D.

4/27 1921 (Address) 5 N. Washington Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bells Cem	Apl 29 1924
20 UNDERTAKER Fleming & Co	ADDRESS ... Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Kleiber)

D 53259 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. House Good Shepard St.: 19 WARD) REGISTERED No. C 172

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula, Klixal Kleiber

(Residence in Baltimore: No. House Good Shepard St.; yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.)
F.	White	Single.

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
17 yrs. 7 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), unknown

PARENTS.

10-NAME OF FATHER, Wm Kliber

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Brumfield

(Address) Edelsburg Md.

15- Robert P. Harrison,

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 27, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fracture (accidental)
Fall. Jump Under
(Duration) yrs. mon. 1 ds.
CONTRIBUTORY (Secondary) Exhaustion
(Duration) yrs. mos. ds.

(Signed) G. E. Radcliffe M. D.
(Coroner)
4/27/21 191... (Address) 1426 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Secretary Wharf — DATE OF BURIAL, April 27 1921

20-UNDERTAKER Wm J. Tiefner & Sons — ADDRESS 24 N. Ave

P. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PR 27 1921 Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53260 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53260

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH US. Public Health Hosp #56 Fort McHenry Baltimore Md.

CITY OF BALTIMORE: (NO. 9 ST.: 30 WARD) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lud C Glenn

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST., 30 WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred Not Resident How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25 yrs.	---	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: laborer

(b) General nature of industry, business, or establishment in which employed (or employer): -----

(c) Name of employer: --

9 BIRTHPLACE (city or town) (State or country): S.C.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Edgar T Rosenbrock Registrar US. Public Health Hosp: #56

15 Filed Apr 27 1921 Robert P. Harrison Registrar

Burial Permit Issued

APR 27 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1921

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to April 24, 1921, that I last saw him alive on Arpil 24, 1921, and that death occurred, on the date stated above, at 12'30 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary (active)

(duration) 2 yrs. -- mos. -- ds.

CONTRIBUTORY (Secondary) --- (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Thomas R. Payne, M. D.

Senior Surgeon (R)

, 19 (Address) US. PHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery DATE OF BURIAL: April 28 1921

20 UNDERTAKER: L. Leinster & Bro ADDRESS 1127 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ... state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... TION is very important. See instructions on back of certificates.

D 53261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53261

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Locust St. ST.: 25 WARD)

2-FULL NAME Gustav Brauckhoff, Jr. Curtis Bay

(a) RESIDENCE. NO. 7 Locust ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) June 22, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Curtis Bay
(State or country) Md.

PARENTS

10 NAME OF FATHER Gustav Brauckhoff, Sr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Tanker

13 BIRTHPLACE OF MOTHER (city or town) Curtis Bay
(State or country) Md.

14 Informant Gustav Brauckhoff Jr.
(Address) 7 Locust St. Curtis Bay

15 Filed ..... 19 Robert F. Harrison, Registrar

APR 27 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1921

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1921, to April 27, 1921, that I last saw h.. alive on April 27, 1921, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria
(Laryngeal)
(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) Geo. Dan[illegible] M. D.

4/27 1921 (Address) 211 Church St. Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A.A Co	4/28 1921
20 UNDERTAKER William Cook	ADDRESS 501 E North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53262 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53262

169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Canton Harbor ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis C. Matthai

(Residence in Baltimore: No. 1701 E. Lafayette Ave. St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Don't Know, 1 (Month) (Day) (Year)

7-AGE, abt 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Christian E. Matthai

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Elizabeth Spillman

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. E. Matthai

(Address) 436 E. 20th St.

15- Robert P. Harrison,
Filed ..... 191.... Registrar.
Burial Permit Issued

APR 27 1921

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Investigation find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Paul Fossett M. D. (Coroner)

4/26, 21 (Address) 1100 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, April 28 1921

20-UNDERTAKER William Cook — ADDRESS 502 E. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53263

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 N. Gmo ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlie Johnson

(a) RESIDENCE. NO. 418 N. Gmo ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) August 20, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Kemical works

(c) Name of employer Charles Davidson

9 BIRTHPLACE (city or town) (State or country) Waverly Virginia

PARENTS

10 NAME OF FATHER Frank Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Waverly Virginia

12 MAIDEN NAME OF MOTHER Amanda Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Waverly Virginia

14 Informant (Address) Mrs. Sarah Custards 638 George St.

15 Filed Apr 26 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1921

17 I HEREBY CERTIFY, That I attended deceased from April 19, 19..., to April 25, 1921.

that I last saw h[illegible] alive on April 25, 1921.

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) O K Finan, M. D.

Apr 26 1921 (Address) 712 S Sharp Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	April 29, 1921.
20 UNDERTAKER	ADDRESS
Mrs Katie R. Williams	1114 W. Saratoga St

APR 27 1921 Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53264 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53264

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Agnes Hospital ST.: 25 WARD)

REGISTERED No. C 175-005

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William O'Donnell

(Residence in Baltimore: No. 4 Lee St.; 4 Years yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb. (Month) 14 (Day) 1861 (Year)

7-AGE,	If LESS than 1 day,
60 yrs. 2 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William O'Donnell

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary O'Brien

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary A. O'Donnell

(Address) Elkridge, Md.

15- Filed APR 27 1921, 191.... Robert F. Harrison, Registrar. Deputy Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 25 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
accident

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) G. C. Bladen M. D.
(Coroner.)

4/27/21, 191... (Address) 1430 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Elkridge, Howard Co. Md

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Apr. 27, 1921

20-UNDERTAKER Easton Sons ADDRESS Elkridge Md

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53265 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53265

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1917 Herbert St. 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Patton

(a) RESIDENCE. No. 1917 Herbert St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5

7 AGE: Years 19; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Candy Factory

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Patton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Anna Crowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: John Patton

(Address): 1917 Herbert St

15 Filed 4/27 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26 1921

17 I HEREBY CERTIFY, That I atteaded deceased from Apr 24, 1921, to Apr 26, 1921, that I last saw her alive on Apr 26, 1921, and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. William Frey, M. D.

4/27. 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [redacted] Westernport Md — DATE OF BURIAL: April 28 1921

20 UNDERTAKER: William Cook — ADDRESS: 502 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

4/27 1921

(Cottingham)

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53266

CERTIFICATE OF DEATH.

93

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1602 N Smallwood St.

2-FULL NAME Carrie E Cottingham

(a) RESIDENCE. No. 1602 N Smallwood WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred: Yrs. mos. ds. How long in U. S., if of foreign birth? Yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel b Cottingham

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Mary J Bryant

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mary E Cottingham
(Address) 1602 N Smallwood St

15 Robert F. Harrison
(Signed) Registrar

4/27 1921 Burial Permit Clerk.

In Center Bonnaitz

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1921

17 I HEREBY CERTIFY, That I attended deceased from April 14 1921, to April 27, 1921, that I last saw her alive on April 26, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) 4 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Ovar

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward H London, M. D.

4/27 1921 (Address) 750 N North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olive Cem	April 29 1921
20 UNDERTAKER	ADDRESS
Wm Lach	526 E North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53267 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53267

115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander A Barril

(a) RESIDENCE. No. Drum Point Md ST. ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Not Known ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER John Jos de Barril

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain.

12 MAIDEN NAME OF MOTHER Manuela Lavarria

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain.

14 Informant Records of Mt Hope Retreat

(Address) Mt Hope Md.

15 Filed APR 28 1921 ROBERT A. HAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1926

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1912, to Apr 27, 1921, that I last saw him alive on Apr 26, 1921, and that death occurred, on the date stated above, at 9. PM m.

The CAUSE OF DEATH* was as follows:

Acute Hepatitis

Abt. (duration) yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Manic - Paranoia Type

Unk (duration) yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Drum Point Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	4/28 1921
20 UNDERTAKER Henry W. Meas & Son	ADDRESS 905 N. Calvert St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Every item of information

Spec.—6-9-19—H. P. Co.—1000 Bks.

Furby

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53268

REGISTERED NO. 79 D 53268

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S. Sharp ST. 72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Furby

(a) RESIDENCE. No. 316 S. Sharp ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or ~~divorced~~ HUSBAND of ~~(or) WIFE of~~: Alida D. Furby

6 DATE OF BIRTH (month, day, and year): Feb, 1852

7 AGE: Years 69 | Months 2 | Days (unknown) | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Board House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Burke Co. North Carolina

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unk

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Katie Crockett
(Address): 1321 W. Mosher St

15 Filed APR 28 1921 ROBERT I. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): apr, 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan, 16, 1921, to apr, 25, 1921, that I last saw her alive on apr, 25, 1921, and that death occurred, on the date stated above, at 11 P, m.

The CAUSE OF DEATH* was as follows:
Chronic myocarditis
And chronic
Endocarditis
(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Auricular Fibrillation (duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) David Fraenkel, M. D.
4/26, 1921 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: apr 28 1921

20 UNDERTAKER: Jno. H. Toadvine

ADDRESS 1142 Ursid St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 53269

HEALTH DEPARTMENT—CITY OF BALTIMORE

18 D 53269

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Simpson

(a) RESIDENCE. NO. 525 W West St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16 - 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed APR 28 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1921

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1920, to April 27, 1921, that I last saw h in alive on April 27, 1921, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct

DATE OF BURIAL: April 29 1921

20 UNDERTAKER: S. H. Browne and Son

ADDRESS: 10 W Mulberry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53270

CERTIFICATE OF DEATH.

28 D 53270

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1124 Montpelier St.; 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Hughes.

(a) RESIDENCE. No. 1124 Montpelier St., ... Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lata J. Hughes.

6 DATE OF BIRTH (month, day, and year) July 5: - 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Lone Hollaree

(c) Name of employer Lone Hollaree Co. Balt Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Fredk Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Linkston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ed. Hughes (Address) 1124 Montpelier st

15 Filed APR 28 1921 ROBERT F. [illegible] Registrar

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 24th, 1921, to Apr 25th, 1921, that I last saw h-- alive on Apr 25th, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Interculsis Pulmonalis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs Microscopic

(Signed) Lonco Linton, M. D.

Apr 28th, 1921 (Address) 1114 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	April 28 1921

20 UNDERTAKER George F. Ruth. ADDRESS 1735 Hayford Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53271

CERTIFICATE OF DEATH.

28 D 53271

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis ST. ~~Unknown~~ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura James

(a) RESIDENCE. No. 613 George st. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ~~Unknown~~ Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward James. ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Davis Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Unknown~~ Maryland

12 MAIDEN NAME OF MOTHER Emma Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed APR 28 1921 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1921, to April 25, 1921, that I last saw her alive on April 25, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) F. J. Rigney, M. D.

4-25-21 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Apr 28 1921
20 UNDERTAKER Samuel Hendley	ADDRESS 578 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53272 HEALTH DEPARTMENT--CITY OF BALTIMORE Krisman

CERTIFICATE OF DEATH

104 D 53272

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 2909 Eastern Ave ST.: 1 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leon F Krisman

(Residence in Baltimore: No. 2909 Eastern ave St.: 1/2 yrs. ... mos. ... ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: August 13, 1919 (Month) (Day) (Year)

7-AGE: 1 yrs. 8 mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Michel Krisman

11-BIRTHPLACE OF FATHER (State or country): Baltimore

12-MAIDEN NAME OF MOTHER: Katie Salerner

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Michael Krisman

(Address) 2904 Eastern ave

15. APR 28 1921 ROBERT I KRAUTER Registrar of Vital Statistics Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April 27, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25, 1921, to April 27, 1921

that I saw him alive on April 27, 1921,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

and Enteritis

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY)

(Duration) ... yrs. ... mos. 3 ds.

(Signed) D.T. Mohr M.D.

27 April, 1921 (Address) 3015 Ellwood ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: St. Stanislaus Cem.

DATE OF BURIAL: April 29, 1921

20-UNDERTAKER: W F Sadowski

ADDRESS: 705 S. Ann St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 607 So. Wolfe ST. 2nd. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOSEPH SOJKA,

(a) RESIDENCE. No. 607 So. Wolfe ST., 2nd. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tinnie Sojka,

6 DATE OF BIRTH (month, day, and year) March 19-1893.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	I	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Paul Sojka,

9 BIRTHPLACE (city or town) (State or country) Powiat, Ropczyce, Poland,

PARENTS

10 NAME OF FATHER Antoni Sojka,

11 BIRTHPLACE OF FATHER (city or town) Powiat (State or country) Ropczyce, Poland,

12 MAIDEN NAME OF MOTHER Julia Grecka,

13 BIRTHPLACE OF MOTHER (city or town) Powiat, (State or country) Ropczyce, Poland,

14 Informant Mrs. Tinnie Sojka, (WIFE)
(Address) # 607 So. Wolfe Street

15 Filed APR 28 1921 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27- 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 25 21, 19.., to April 27 21, 19..,
that I last saw h— alive on April 27, 19 21,
and that death occurred, on the date stated above, at 2.50 A- m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Krawet, M. D.

4/27/21 19 (Address) 801 Kenyon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	April 29" 1921.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 905 S. Ann.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 53274

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 So. Durham ST.: 2nd. WARD)

2-FULL NAME ANNIE DOBRZYKOWSKA,

(a) RESIDENCE. No. 706 So. Durham ST., 2 nd. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 41 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Widow,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Dobrzykowski,

6 DATE OF BIRTH (month, day, and year) Unknown, ----1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at home,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) POsen, (State or country) Poland,

PARENTS

10 NAME OF FATHER Joseph Lewandowski,

11 BIRTHPLACE OF FATHER (city or town) Posen, (State or country) Poland,

12 MAIDEN NAME OF MOTHER Jozefa Limanska,

13 BIRTHPLACE OF MOTHER (city or town) Posen, (State or country) Poland,

14 Informant William Dobrzykowski, (Son)

(Address) 706 So. Durham Street

15 Filed APR 28 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27- 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1921, to April 27, 1921, that I last saw him alive on April 27, 1921, and that death occurred, on the date stated above, at 7.40 A- m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mes. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mes. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

April 27, 1921 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.	April 30" 1921.

20 UNDERTAKER W. F. Sadowski. ADDRESS 905 S. Ann St.

mation should be carefully supplied. Age should be stated EXACTLY. Particulars should be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Butler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53275

CERTIFICATE OF DEATH.

40

D 53275

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N Spring ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F Butler

(a) RESIDENCE. No. 419 N Spring ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Butler

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years	Months	Days	If LESS than 1 day, hrs. or min.
41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer) (

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm Moore

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) Scotland
(State or country)

14 Informant Husband
(Address) Mrs Butler 419 N Spring

15 Filed ..... 19 ..... Registrar

APR 22 1921 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 24, 19 21, to Apr 25, 19 1,
that I last saw h alive on Apr 25, 19 1,
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

Gastric Cancer

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) H. C. Burns, M. D.

Apr 26 19 (Address) 422 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL APR 28 1921 19

20 UNDERTAKER R C Gross

ADDRESS 1405 McElderry St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53276

CERTIFICATE OF DEATH.

1921 D 53276

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Sq. Hospital ST.: WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor Williams

(Residence in Baltimore: No. 1304 N Stricker St.)

(If non-resident give STATE or COUNTRY.) (If under 1 year, 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fe

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 20, 1918
(Month) (Day) (Year)

7-AGE, 3 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Thomas Williams

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Theleneer Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theleneer Thomas

(Address) 1304 N Stricker St

15-

Filed APR 28 1921, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns (Matches) 4 hrs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) H. C. Hall M. D.
(Coroner)

4/27/21 (Address) 1736 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, APR 27 1921, 19....

20-UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

Has Payne previously practiced.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53277

CERTIFICATE OF DEATH.

64

D 53277

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N. Chapel. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Wolf

(a) RESIDENCE. No. 407 N. Chapel. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 12/1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Commission

(c) Name of employer Merchant

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Wolf

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Kandutsky

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Harry Wolf
(Address) 407 N. Chapel

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26/21

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1921, to Nov 26, 1921, that I last saw him alive on Nov. 20, 1921, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis Left Side.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phy. Exam.

(Signed) J. C. Gladis, M. D.

(Address) 1436 Bway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mathew's Cem	Nov. 29 1921

20 UNDERTAKER Philip J. Herwig ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53278

CERTIFICATE OF DEATH.

28 D 53278

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 N. Hoffman St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Wineberg

(Residence in Baltimore: No. 605 N. Hoffman St. St.; 5 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, April 9 (Month) (Day), 1897 (Year)

7-AGE, 24 yrs. ..... mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Lewis Wineberg

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan Diggs

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis Wineberg

(Address) 605 N. Lansdale St

15-

APR 28 1921 ROBERT P. BRAUNE

Filed....., 191.....

Burial ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 26 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from April 13 1921, to April 26 1921, that I saw h.. alive on April 26 1921, and that death occurred, on the date stated above, at 1:20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward J. Wheatley M. D.

4/27, 1921. (Address) 1730 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	April 28, 1921
20-UNDERTAKER	**ADDRESS**
David Earlys	706 Penna Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

14 D 53279 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53279

CERTIFICATE OF DEATH. 26

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Williams

(a) RESIDENCE. No. 537 Mission Court ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5 - 1897.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	1	21.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House - work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Gaithrye

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Parker.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed APR 28 1921 ROBERT E. LAMBERT Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7- , 1921, to April 26 , 1921, that I last saw her alive on April 26 , 1921, and that death occurred, on the date stated above, at 3 15 a. m.

The CAUSE OF DEATH* was as follows:

Exhaustion & inanition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pellagra

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical findings

(Signed) Edward C. Jordan M. D.

4-26, 19 21 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn bur	April 29 1921
20 UNDERTAKER Daniel Easton	ADDRESS 916 Ea ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53280

CERTIFICATE OF DEATH.

91 D 53280

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Nieman

(a) RESIDENCE. NO. 1316 Steever St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: James Browning

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Hospital Records,
(Address): New City Hospital.

15 Filed 1921 19 Registrar

Burial Permit 01[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1921, to April 26, 1921, that I last saw her alive on April 25, 1921, and that death occurred, on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
No cerebral hemorrhages.
(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) B. Eisenman, M. D.

4/26/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Apr 28 1921
20 UNDERTAKER: Joseph B. Cox	ADDRESS: 1003 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. R. Co.—1000 Bks.

D 53281

Wm Cleary.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53281

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Cleary

(a) RESIDENCE. NO. 2528 Woodbrook Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10, 1873

7 AGE	Years	Months	Days	if LESS than 1 day, hrs. or min.
	47	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Mc Clain

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Bridget Hanahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mercy Hospital (Address)

15 Filed APR 28 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/21, 1921, to 4/26, 1921, that I last saw h[illegible] alive on 4/26, 1921, and that death occurred, on the date stated above, at 12.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Abscess

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Simon O. Brady M. D.

4/26 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ct. Druitonty St. Louis	4/28/1921

20 UNDERTAKER Margaret G. Fitzpatrick ADDRESS 1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53281

STATE OF MARYLAND, CITY OF BALTIMORE, to wit:-

I HEREBY CERTIFY that on this 16th day of June in the year one thousand nine hundred and twenty one, before me the subscriber a Notary Public of the State of Maryland in and for the City of Baltimore aforesaid, personally appeared Irwin A Ridgely, and made oath in due form of law that the above facts are true as therein states to the best of his knowledge and belief.

WITNESS my hand an Notorial Seal

Notary Public.

Baltimore, Md.

D 53281

MERCY HOSPITAL
CONDUCTED BY THE SISTERS OF MERCY
CALVERT & SARATOGA STS.
BALTIMORE, MD.

June 15, 1921.

o Whom It May Concern:

This is to certify that the records of Mercy Hos-
ital showing that William Cleary was married at the time of his
eat h is incorrect. The record should show that he was single .

Signed. Irwin D. Ridgely, M. D.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D4732282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53282

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edward Jackson.

(a) RESIDENCE. NO. 525 East St City ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Edward Jackson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Elizabeth Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Johns Hopkins Hospital Records.
(Address)

15 Filed APR 28 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1921

17

I HEREBY CERTIFY, That I attended deceased from April 23. 1921, to April 26, 1921, that I last saw him alive on April 26, 1921, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH was as follows:

Terminal hemolytic streptococcemia
broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Active pulmonary T.B.

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological findings

(Signed) Edward C. Rhoades, M. D.

4-27-21 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	April 28 1921
20 UNDERTAKER John W Henderson	ADDRESS 1502 Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53283

CERTIFICATE OF DEATH.

109 D 53283

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N. Dallas ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Smith

(a) RESIDENCE. No. 612 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Smith

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary Smith
(Address) 612 N Dallas St

15 Filed APR 28 1921, 19.. Registrar
Burial Permit 01681

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1921, to April 26, 1921, that I last saw h[illegible] alive on April 26, 1921, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

4-26 1924 (Address) 822 N. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	April 1924
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: ? WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jonkavitz

(a) RESIDENCE. No. 2324 Foster Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Rosie (wife)

6 DATE OF BIRTH (month, day, and year): ? ?. 1865

7 AGE: Years 56 Months ? Days ? If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. O&P

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: Jas Jonkavitz.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Agnes ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Johns Hopkins Hospital, Baltimore

15 Filed: APR 28 1921 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1921

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1921, to April 27, 1921, that I last saw him alive on April 27, 1921, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

~~Acute~~ Chr.

Cardiac Failure

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Carcinoma of rectum

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? In hospital

Did an operation precede death? Yes Date of 4/2/21.

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A. Blume, M. D.

4-28, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus

DATE OF BURIAL: April 30 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E. Watt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53285 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53285

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 151 Enon St cor Dolphin + Hoffman ST.: 11 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Davis

(a) RESIDENCE. No. 151 Enon St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Davis

6 DATE OF BIRTH (month, day, and year) Mar 27 93

7 AGE 27 Years Months 27 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Kate Davis

(Address) 151 Enon alley

15 Filed APR 28 1921 ROBERT F. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 25, 1921, that I last saw him alive on April 24, 1921, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis of Lungs.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration) yrs. 6 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Wm. Kennard M. D.

4-25 1921 (Address) 708 Enon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem'y	Apr 28 1921
20 UNDERTAKER George H. Holland	ADDRESS 1631 Kennedy Hillsan

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 53286

D 53286

CERTIFICATE OF DEATH

REGISTERED NO. C 79

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1539 Ebbalston St ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Eleanor Jenkins

(Residence in Baltimore: No. 1539 Ebbalston St St.; 63 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F

4-COLOR OR RACE W

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH July (Month) 15 (Day), 1864 (Year)

7-AGE 56 yrs. 9 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER George T. Ford

11-BIRTHPLACE OF FATHER (State or country) Maryland

12-MAIDEN NAME OF MOTHER — — Cripps

13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Jenkins

(Address) 1539 Ebbolston St

15- APR 28 1921 ROBERT J. KRAUER

Filed 191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1921, to, April 26 1921, that I saw her alive on April 26 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 5 yrs. mos. ds.

Contributory (SECONDARY) Elephantiasis Xtmbs

(Duration) 5 yrs. mos. ds.

(Signed), Fritz J Dimzey M. D.

April 26, 1921 [Address] 2700 Howard

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Parkwood Cem. DATE OF BURIAL April 27th 1921

20-UNDERTAKER Leo G. Cook ADDRESS North & Hayward

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should

(Euripidis Ballalas)

Spec.—6-9-19—H. P. Co.—1000 Bks.

140 28 D 53287

HEALTH DEPARTMENT—CITY OF BALTIMORE D 53287

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eurimidis Ballalas.

(a) RESIDENCE. NO. 145 - 6th Ave. ST.. New York City. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14 - 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	1	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece.

12 MAIDEN NAME OF MOTHER ?.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed ....., 19.....

Robert P. Harrison.

Burial Permit Clerk. Registrar

R 28 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 19 , 1921 , to Apr. 26 , 1921 , that I last saw h.. alive on Apr. 26 , 1921 , and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.
Intestinal "

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic intestinal nephritis
Supra-pubic fistula (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? New York.

Did an operation precede death? Yes. Date of Dec. 11, 1919

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H. H. Hailey. M. D.

4, 28, 19 21 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
(Brooklyn New York)	Apl 28 1921
20 UNDERTAKER H. A. Stiglitz	ADDRESS 1321 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53288 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 635 N Calvert St. ST.: 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME M. H. Riddell

(Residence in Baltimore: No. 635 N Calvert St.

St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 67 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Show Man
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Not Known

PARENTS.

10-NAME OF FATHER, —

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address) .....

15- Robert P. Harrison,

Registrar.

APR 28 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 15, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to Her death on the day stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) G C Kelly M. D.
(Coroner)

....., 191... (Address) 1428 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, ...

DATE OF BURIAL, APR 28 1921

20-UNDERTAKER .....

ADDRESS .....

JOHNS HOPKINS HOSPITAL

Commissioner Health.

WOODALL

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53289

CERTIFICATE OF DEATH.

X 115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital — ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edw. Renehan —

(a) RESIDENCE. No. Spring Grove Asylum ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than I day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attendant State Hospt

(b) General nature of industry, business, or establishment in which employed (or employer) 1861

(c) Name of employer State Hospt.

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER Wm Renehan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E Renehan

(Address) 1904 Penna Av

15 Filed ....., 19.... Robert P. Harrison, Registrar

APR 28 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27/21 19

17 I HEREBY CERTIFY, That I attended deceased from 4/18 ....., 1921, to 4/27/21, 19....,

that I last saw him alive on 4/27/21, 19....,

and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis — (over)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 4/23/21

Was there an autopsy? no.

What test confirmed diagnosis? Operation —

(Signed) C. S. Coster, M. D.

4/27, 1921 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Libertytown Frdk Co.	4/30, 1921
20 UNDERTAKER	ADDRESS
Martin Parker & Sons	1827 W North Av

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operations
Gall Bladder

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 53290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53290

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. ..... St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Joseph Lawrence Hoffman

(a) RESIDENCE. No. 3484 Clairemont St., Ward. St. Chas. Hall,
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 9. 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Foreman

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Bethelem St Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Louis A. Hoffman

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Regan

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mrs. R. H. W. Rhoner
(Address)

15 Filed Robert P. Harrison, Registrar

4281921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26- 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15-20, 1921, to April 26, 1921, that I last saw h.im alive on April 26, 1921, and that death occurred, on the date stated above, at 4.45 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Peritonitis

11 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W M Craig, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Josephs Cemetery Texas Md	4-29 1921
20 UNDERTAKER J Q Moran	ADDRESS 3000 E Baltof.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 53291

D 53291

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 E. Biddle St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry R. Simms

(a) RESIDENCE. NO. 921 E. Biddle St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced~~ (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ebenora Simms

6 DATE OF BIRTH (month, day, and year) May 29 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Straw Hat Presser

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer M. S. Levy

9 BIRTHPLACE (city or town) (State or country) Bethesda Co

PARENTS

10 NAME OF FATHER James W. Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co

12 MAIDEN NAME OF MOTHER Catherine E. McCloy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co

14 Informant Ebenora Simms
(Address) 921 E. Biddle St

15 Filed Robert P. Harrison, Registrar

2 81921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19 21 to Apr 27 19 21,
that I last saw h~~im~~live on Apr 27 19 21,
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes -

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) H. Bryson, M. D.

(Address) 1228 Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: April 30 19 21

20 UNDERTAKER: Jos Goodens Son — ADDRESS: 217 S. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53292

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3412 Belair Rd ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Muriel Knapp

(Residence in Baltimore: No. 3412 Belair Rd St.; 28 yrs., 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (*Write* the word.) M

6-DATE OF BIRTH, Dec. 18, 1893
(Month) (Day) (Year)

7-AGE, 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Edward S Myers

11-BIRTHPLACE OF FATHER (State or Country), Balto Co.

12-MAIDEN NAME OF MOTHER Sallie Geary

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. G. Myers

(Address) 3412 Belair Rd

15-

Dec. ....., 191.....

Registrar.

R 2 8 1921 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1919, to to April 27 1921, that I saw h e alive on April 26 1921, and that death occurred, on the date stated above, at 4:57 m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Gustave A Fut M. D.

4/27, 1921. (Address) Overlea

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	April 29, 1921.
20-UNDERTAKER	ADDRESS
Jos Snerdens Son	217 S. Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53293 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53293

CERTIFICATE OF DEATH.

REGISTERED NO. 70

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2204 Montebello Ave (Ward) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bradford S Whitmire

(a) RESIDENCE. No. 2204 Montebello St., ...Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9/1920

7 AGE: Years | Months: 4 | Days: 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Otha M Whitmire

11 BIRTHPLACE OF FATHER (city or town) (State or country): Roanoke Va

12 MAIDEN NAME OF MOTHER: Janet Sheen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Roanoke Va

14 Informant: Otha M Whitmire
(Address) 2204 Montebello Ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to April 28, 1921, that I last saw him alive on April 28, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH was as follows:

Septicemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Infection of Kidney

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/14/21

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter C. Bacon, M. D.

4/25, 1921 (Address) 101 E 20th St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Roanoke Va	April 29 1921
20 UNDERTAKER	ADDRESS
Wm Cockrell & Roanoke	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53294

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53294

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Banner Road ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph B Gilmore.

(a) RESIDENCE. No. 3808 Banner Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca J Gilmore

6 DATE OF BIRTH (month, day, and year) Mch 10 - 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER J H Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz. Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Walter Frey - 3808 Gilmore Banner Road

15 Filed APR 28 1921 19 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. - 28 - 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1921, to April - 28, 1921, that I last saw him alive on April 28, 1921, and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy. with Hemiplegia paralysis. and Heart Failure

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

4/28 1921 (Address) 720 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ridge Cem	May 2 1921
20 UNDERTAKER W. J. Tickner & Sons	ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53295 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hop. St.: 15th Ward) REGISTERED No. C 172

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Louis Kopp

(Residence in Baltimore: No. 1930 N. Payson St.; 61 yrs., 3 mos. 15 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, January 13, 1860
(Month) (Day) (Year)

7-AGE, 61 yrs. 3 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Shipbldg. Co

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. Kopp

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline Gath

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm L. Kopp

(Address) 1930 N. Payson St

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

APR 28 1921 Burial Permit Issued

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 26, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute peritonitis

(Duration) ....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary) Infected Hemorrhoidectomy about

(Duration) ....yrs....mos. 8 ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

April 28, 1921 (Address) 2802 E. Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos. 12 ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? Md. Gen. Hop.

Former or usual residence 1930 N. Payson St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Solomons Md	April 30, 1921
20-UNDERTAKER	ADDRESS
W. J. Tickner & Sons	North Penna

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53296

CERTIFICATE OF DEATH.

8-041 D 53296

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3208 Garrison Ave ST.; 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Imogene Caulk

(Residence in Baltimore: No. 3208 Garrison Ave St.; 3 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, 7 (Month) 31 (Day) 1917 (Year)

7-AGE, 3 yrs. 9 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Walter H. Caulk

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Emma B Becker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter H. Caulk

(Address) 3208 Garrison Ave

15- APR 29 1921 Filed....., 191.... Burial Permit Issued

MOSES J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 29 1921, to Apr 28 1921, that I saw h[er] alive on Apr 28 1921, and that death occurred, on the date stated above, at 2.10 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration)..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) 2 yrs. ..... mos. 0 ds.

(Signed) Emma L. Kahn M. D.

Apr. 28, 1921 (Address) 910 N. Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Loudon Park DATE OF BURIAL, Apr 30 1921

20-UNDERTAKER Geo. W. Lide ADDRESS 27 N Edmondson

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53297

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53297

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3026 Westwood Ave St.; 15 WARD) 15-64

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Irwin

(Residence in Baltimore: No. 3026 Westwood Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Widow

6-DATE OF BIRTH, Mar (Month) 17 (Day), 1842 (Year)

7-AGE, 79 yrs. 1 mos. 9 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Nothing
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John McKernan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dontknow

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Irwin.

(Address) 3026 Westwood Ave

15- ROBERT J KRAUTER

Filed ....., 191.... Burial Permit Clerk

Registrar.

APR 29 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 5 1921, to April 26 1921, that I saw h[illegible] alive on April 26 1921, and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ... yrs. 3 weeks mos. ..... ds.

CONTRIBUTORY (Secondary) Cystitis

..... (Duration) ... yrs. ..... mos. 3 ds.

(Signed) Chas. H. Talbot M. D.

April 29 1921 (Address) 1100 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, April 29, 1921

20-UNDERTAKER Josiah Lefler

ADDRESS 1600 N. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53298

D 53298

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 N. First St Bro ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Anderson

(a) RESIDENCE. NO. 202 N. First St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ ~~ds.~~ How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower

6 DATE OF BIRTH (month, day, and year): May 23, 1839

7 AGE: Years 81 Months 5 Days 2 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Marine engineer

(b) General nature of industry, business, or establishment in which employed (or employer): 130

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pittsburg Pa

PARENTS

10 NAME OF FATHER: Robt Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Ackman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mary A Lewis

(Address): 2 N Eutaw St

15 Filed APR 29 1921 HENRY F. TRAUTEN Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27th 1921

17

I HEREBY ~~CERTIFY~~, That I attended deceased from April 24th, 1921, to April 27th, 1921, that I last saw him alive on April 26th, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Aortic Insufficiency

of Heart

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Fleibel M. D.

4/28, 1921 (Address) 1210 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: 4-29 1921

20 UNDERTAKER: Wm. J. Evans Sons — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53299

CERTIFICATE OF DEATH.

126 D 53299

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6312 N. Fulton av ST.) 16 WARD)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A. Simms Jr

(Residence in Baltimore: No. 6312 N. Fulton Ave, St.) 39 yrs., mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, W,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 2, 1836
(Month) (Day) (Year)

7-AGE 84 yrs. 7 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), St Marys Co. Md

PARENTS.

10-NAME OF FATHER, Francis Simms

11-BIRTHPLACE OF FATHER (State or Country) St Marys Co Md

12-MAIDEN NAME OF MOTHER Mary A. Greenwell

13-BIRTHPLACE OF MOTHER (State or Country), St. Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Simms

(Address) 6312 N. Fulton Ave.

15- APR 29 1921 Filed....., 191.... ROBERT J. KRAUTER Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 23 1921, to Apr 28 1921, that I saw him alive on Apr 27 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy Prostate - cystitis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile - exhaustion

(Duration) yrs. 1 mos. ds.

(Signed) Homer L. Todd M. D.

4/28, 1921. (Address) 735 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, April 30, 1921

20-UNDERTAKER George J. Smith — ADDRESS 1000 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53300

CERTIFICATE OF DEATH.

'21 D 53300

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 Ething ST.; 1st WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosbin L Johnson

(Residence in Baltimore: No. 2316 Ething St.; ...yrs., 6 mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, abt 2-5, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. ...ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edward Johnson

11-BIRTHPLACE OF FATHER (State or Country), N C

12-MAIDEN NAME OF MOTHER Ellen Bagwell

13-BIRTHPLACE OF MOTHER (State or Country), S C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H Dennis

(Address) 1303 Prestman St

15- ANNIE E ABAJIAN

Filed APR 29 1921 Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 27, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 25 1921, to Apr 26 1921, that I saw him alive on Apr 26 1921, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

.....

.....

(Duration) ...yrs. 1 mos. ...ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ...yrs. 3 mos. ...ds.

(Signed) ... M. D.

Apr 27, 1921. (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, APR 29 1921, 191...

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53301

CERTIFICATE OF DEATH.

8-04 B 53301

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Bayard ST.: 21 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Butler

(a) RESIDENCE. No. 1305 Bayard ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER William Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Florence Anderson
(Address) 1305 Bayard St

15 Filed APR 29 1921 ROBT. J. KRAUER Registrar
Burial Permit Issued Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1921, to April 27, 1921, that I last saw her alive on April 26, 1921, and that death occurred, on the date stated above, at 2.55 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping Cough ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Signs

(Signed) Dr. Wesley Stokes, M. D.

4/28 1921 (Address) 729 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Fri 29
20 UNDERTAKER	ADDRESS
Daniel Easton	Ea ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53302

CERTIFICATE OF DEATH.

64 ✓ D 53302

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Hanover ✓ St.: 23 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Sidney Harding

(a) RESIDENCE. No. 902 Hanover ✓ St., Ward. England

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Harding

6 DATE OF BIRTH (month, day, and year) Dec 31 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Instrument Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER James C. Harding

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary A. Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Emily Hurst

(Address) 902 Hanover St

15 APR 29 1921 ROBT. F. CHAUTEN Registrar

Burial to be made Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 29, 1921.

that I last saw him alive on April 29, 1921.

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Paralysis

Duration) ..... yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. Hammerbach M. D.

April 30, 1921 (Address) 835 Lytle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	May 2 1921
20 UNDERTAKER	ADDRESS 1034
E. Schlosnagle & Son	Hanover st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53303 HEALTH DEPARTMENT--CITY OF BALTIMORE 1921 76 545 D 53303

CERTIFICATE OF DEATH

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 316 Harwood Ave ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary A. L. Croswell

(Residence in Baltimore: No. 316 Harwood Ave St.: Lf 2 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH Jan 2 (Month), (Day), 1845 (Year)

7 AGE 76 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Brantley D. Croswell

(Address) 316 Harwood Ave

15 Filed APR 29 1921 ROBERT F KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 28 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1921, to April 28 1921, that I saw her alive on April 28, 1921, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. H. Jennings M.D.

April 28, 1921 (Address) 1107 Eutaw Pl. Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Lowell	Apr 30 1921
20 UNDERTAKER	ADDRESS
Wm Cook	501 E North Ave

D 53304

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53304

CERTIFICATE OF DEATH.

REGISTERED NO. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 219 n Spring ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary McCabe

(Residence in Baltimore: No. 219 n Spring St.; yrs., 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, Dec. (Month) (Day), 1870 (Year)

7-AGE.	If LESS than 1 day,
50 yrs. 5 mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Dorman

(Address) 2028 Eutaw Pl

15- FILED APR 29 1921 ROBERT J. KRAUTER Registrar of Burial Permits Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D. (Coroner)

4-28, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St. Vincent	Apr. 29 1921
20-UNDERTAKER Philip Herring	ADDRESS 2016 Ollenus St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53305

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53305

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. General Hospital St. 6 WARD)

REGISTERED No. C 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Lavinia Roerentrop

(Residence in Baltimore: No. 1913 W. Fayette St. St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, October (Month) 1st (Day), 1861 (Year)

7-AGE, 59 yrs. 6 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife at home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Reinhardt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Regina Hitzell

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Wm. Roerentrop

(Address) 1913 W. Fayette St.

15- Filed APR 29 1921 ROBERT A KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 26th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General peritonitis

(Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Degeneration fibroid tumor of uterus & abscess of broad ligament

(Duration) .....yrs. .....mos. .....ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

April 25 1921. (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

1913 W. Fayette St.

Former or usual residence ..... same .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Apr. 29th, 1921

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53306

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 64 D 53306

1-PLACE OF DEATH USPHS Hosp. #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Ft. McHenry, Baltimore, Md. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joel Gayle

(a) RESIDENCE. No. USPHS Hosp. #56, Ft. McHenry, Md ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Lottie Gayle

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer): ----------

(c) Name of employer: ----------

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): ----

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ----------

14 Informant: Edgar T. Rowbrook Registrar

(Address) USPHS Hosp. #56, Ft. McHenry, Md

15 Filed APR 29 1921 19 ROBERT F. FRAUTEN Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28, 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1921, to April 28, 1921, that I last saw him alive on April 28, 1921, and that death occurred, on the date stated above, at 1:15 Pm.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum-Arterial Sclerosis general, Nephritis chronic Interstitial

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) ----------

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ----------

Did an operation precede death? No Date of ------

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Thomas P. Payne, Senior Surgeon (P.) M. D.

, 19 (Address) USPHS Hosp. #56, Ft. McHenry, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Apr. 30 1921

20 UNDERTAKER: Wm. C. Black ADDRESS 927 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53307

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53307

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 12 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Coster

(Residence in Baltimore: No. 435 Pinkney Place St.: 5Mt yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May (Month) 25th (Day) 1918 (Year)

7-AGE, ... yrs. 11 mos. 3 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Child

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. G. Coster

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Mabel Armstrong

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel Coster

(Address) 435 Pinkney Place

15- APR 29 1921 Filed ....., 191.... Burial ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Apl (Month) 28 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Burns.

Accidentally Fell Down

a pushed in front of last motor

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... 6 ..... M. D. (Coroner.)

Apl 29, 1921 (Address) ..... 1655 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem Harford Rd

DATE OF BURIAL, 4/30, 1921

20-UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Harford Ave

U. S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53308 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. John Hopkins ST.: V WARD) 175-00

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Gleisner

(Residence in Baltimore: No. 417 S. Washington St.: 9 yrs., 2 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb (Month) 16 (Day), 1902 (Year)

7-AGE, 19 yrs. 2 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Julius Gleisner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Louise Schumacher

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Louise Gleisner
(Address) 417 S. Washington St.

15- APR 29 1921, 191.....
Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Rheumatism 1st Yrs
Endocard (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. Dudley M. D. (Coroner.)
4-28, 1921 (Address) 1 E. Read

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel | DATE OF BURIAL, April 30 19....

20-UNDERTAKER Peter Nicolaus | ADDRESS 2046 Eastern Av

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53309

D 53309

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1879 Hillsdale St. Ward) 19

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Crofoot

(a) RESIDENCE. No. 1879 Hillsdale St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 28, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Campbell Crofoot

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER Annie E Botts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Campbell Crofoot
(Address) 1879 Hillsdale St

15 Robert P. Harrison, Registrar

R 29 1921

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27 1921.

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 1921, to Apr 27, 1921, that I last saw h[illegible] alive on Apr 27, 1921, and that death occurred, on the date stated above, at 145 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James L Rosenberger, M. D.

4/28 1921 (Address) 1729 N Longwood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apr 29 1921
20 UNDERTAKER Harry H Fitzke	ADDRESS Loudon Park Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53310

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 Mt. Olivet La ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd J Purcell

(a) RESIDENCE. No. 328 Mt Olivet La ST., 70 WARD. Newfoundland N.J.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? 66 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of (or) WIFE of Catherine Purcell

6 DATE OF BIRTH (month, day, and year) 3-12-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mac Naughton Shoe

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Wm Purcell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs C. Purcell

(Address) 328 Mt Olivet La

15 Filed APR 29 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 10, 1921, to Apr 29, 1921, that I last saw h. alive on Apr 27, 1921, and that death occurred, on the date stated above, at 12'30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Lobular Neptuto.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N. J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W A Purcell, M. D.

4/29 1921 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 1 1921

20 UNDERTAKER John J Fields ADDRESS 1200 N Fulton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53311

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53311

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) St. Agnes Hospital ST.; WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Leo Stempling

(a) RESIDENCE. No. 109 S. Carey St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) April 20 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7 months		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Stempling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Clara Ayler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Clara Stempling (Address) 109 S. Carey St.

15 Filed ....., Robert P. Harrison, Registrar

PR 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 27, 1921, to April 28 1921, that I last saw h[illegible] alive on " 28, 1921, and that death occurred, on the date stated above, at 5:20 p. m.

The CAUSE OF DEATH* was as follows:

Intussusceptum – intestinal obstruction

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-27-21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Wm. McCraig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 30 1921
20 UNDERTAKER John J. Fields	ADDRESS 1200 W. Fayette

IMPORTANT. See instructions on back of certificates.

Dr Griffe

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53312

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Whitelock St.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Slunt

(a) RESIDENCE. No. 1504 Whitelock ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 00 mos. ds. How long in U. S., if of foreign birth? 60 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced (or) WIFE of Charles Slunt

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	don't know		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Coffay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Charles Slunt

(Address) 1504 Whitelock St

15 Filed ..... Robert P. Harrison, Registrar

R 29 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1920, to April 28, 1921, that I last saw her alive on April 28, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows

Carcinoma of breast removed about 1 yr ago.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of liver

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about 1 yr ago

Was there an autopsy? no

What test confirmed diagnosis? Microscopic exam of tissue

(Signed) H E Griffe, M. D.

, 19 (Address) 1002 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 2nd 1921
20 UNDERTAKER	ADDRESS
Martin Faherty & Sons	527 W Fayette St.

Blanks should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 53313

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D 53313

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 Nun ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Bradshaw

(Residence in Baltimore: No. 404 Dean St. St.; ..... yrs., 4 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE, Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Dec 13 (Month) — 20 (Day), 1 (Year)

7-AGE, ... yrs. 4 mos. ..... ds. 15 | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Schaffner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Bradshaw

11-BIRTHPLACE OF FATHER (State or Country), Chestertown Md

12-MAIDEN NAME OF MOTHER Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) 404 New St

(Address) John Bradshaw

15-

Filed ..... 191. Robert P. Harrison, Registrar.

PR 21921 Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 23 1921, to April 28 1921, that I saw him alive on April 27 1921, and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

.....

.....

1 Acute Bronchitis

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Frank B Grimm M. D.

April 29 1921 (Address) 312 N Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. | DATE OF BURIAL, April 30, 1921.

20-UNDERTAKER F. B. Pye | ADDRESS 102 Mulberry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 6 Beechwood Rd, Hampden — REGISTERED NO. C.....

CITY OF BALTIMORE: (NO. ..... E ..... ST.; 7 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Gladys Ireland.

(Residence in Baltimore: No. 6 Beechdale ave St.; 17 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, April 28, 1894 (Month) (Day) (Year)

7-AGE, 27 yrs. 3 mos. 24 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Penna.

PARENTS.

10-NAME OF FATHER. Chas Biandt

11-BIRTHPLACE OF FATHER (State or Country). Penna.

12-MAIDEN NAME OF MOTHER Cathrin Duffy

13-BIRTHPLACE OF MOTHER (State or Country) Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Ireland

(Address) 6 Beechwood Rd.

15- Robert P. Harrison,

Filed ....., 191.....

PR 29 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to April 28 1921, that I saw h.e alive on April 28 191 2, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (Duration) ... yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary) Sarcoma of Palate

..... (Duration) ... yrs. 2 mos. ... ds.

(Signed) John A Evans M. D.

....., 191... (Address) 101 N Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery — DATE OF BURIAL, May 2, 1921

20-UNDERTAKER Harry W. Ehlen — ADDRESS 1944 W. North Ave

Cause of Death to be given in plain terms, as much as may be properly so, is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Gahan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53315

CERTIFICATE OF DEATH.

50

D 53315

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 W Lanvale ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Joseph Gahan

(Residence in Baltimore: No. 1906 W Lanvale St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.)
M	Wh	Married

6-DATE OF BIRTH, ... Sept. (Month) 1 (Day), 1855 (Year)

7-AGE,	If LESS than 1 day,
65 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Richmond - Va

PARENTS.

10-NAME OF FATHER, James Gahan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Cunningham

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen C. Gahan

(Address) 1900 Lanvale St

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

PR 29 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 1 1921, to Apr 26 1921, that I saw h[er] alive on April 21 1921, and that death occurred, on the date stated above, at p m.

The CAUSE OF DEATH* was as follows:

Diabetes — Sepsis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Necrosis L. foot

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Chas F. Blake M. D.

April 29 1921. (Address) 20 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State 40 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Mem cathedral cem	4-30, 191...

20-UNDERTAKER	ADDRESS
Marg. J. Flynn	1422 Light St

EACH OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 S Clinton ST.; 26 WARD)

REGISTERED No. C 7

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred A Sealover

(Residence in Baltimore: No. 301 S Clinton St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov (Month) 29 (Day), 1916 (Year)

7-AGE, 5 yrs. 5 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, John Sealover

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Catherine Lemke

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr John Sealover

(Address) 301 S. Clinton St

15-

Robert P. Harrison,

Filed ....., 191.....

APR 29 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 29 1921, 10-30 am to 3-30 pm April 29 1921, that I saw her alive on April 29 1921, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Isabel V Whitney M. D.

April 29, 1921. (Address) Isabel V Whitney

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
I St Germain	April 30 1921

20-UNDERTAKER	ADDRESS
Peter Nicolaus	2046 Easter

important. See instructions on back of certificate.

Spec.—6—13—H. P. Co.—1000 Bks.

D 53317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 53317

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 N Chapel ST.: 6 WARD)

2-FULL NAME Maximilian Endres

(a) RESIDENCE. No. 204 N Chapel ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Peter Endres

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Cora Koelbel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Peter Endres

(Address) 204 N Chapel

15 Filed ..... 19 Robert P. Harrison, Registrar

Apr 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1921, to April 29, 1921, that I last saw him alive on April 28 1921, and that death occurred, on the date stated above, at 5:10 a.m.

The CAUSE OF DEATH* was as follows:

Indigestion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) convulsions

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. T. Hardy, M. D.

, 19 (Address) 1202 N Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 30 1921
20 UNDERTAKER Wendell Myers Son	ADDRESS 31 Elm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53318

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 W. Hamburg ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank M. Strnat Jr.

(a) RESIDENCE. No. 1135 W. Hamburg ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank M. Strnat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Clara A. Langohr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Frank M. Strnat
(Address) 1135 W. Hamburg st.

15 Filed Apr 30 1921 Robt P. Garrison, Registrar

PR3 01921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1921, to April 29th, 1921, that I last saw him alive on April 28 1921, and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Pyelo-nephritis, Acute

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter E. Grempler, M. D.

19 (Address) 1013 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Apr 30 1921
20 UNDERTAKER	ADDRESS
Mrs. Mrs J. W. Geupel & Son	801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar-pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); ***Measles;*** *Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Had Whooping Cough & Measles in Jan. 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53319 ✓ D 53319

CERTIFICATE OF DEATH.

130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Ashland Ave. ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Gertrude Weiss

(a) RESIDENCE. No. 1111 Ashland Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
(or) WIFE of Philip Geo. L. Weiss.

6 DATE OF BIRTH (month, day, and year) Aug 31 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine J. Kerner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Sonya Mentis
(Address) 1111 Ashland Ave

15 Filed ....., 19.... Robert F. Harrison, Registrar

R 30 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1921

17 I HEREBY CERTIFY, That I attended deceased from April 13th, 1921, to April 28th, 1921, that I last saw her alive on April 28th, 1921, and that death occurred, on the date stated above, at 11.42 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms & Laboratory findings

(Signed) L. M. C. Corkran, M. D.

Apr. 15th, 1921 (Address) 1114 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 2nd 1921
20 UNDERTAKER	ADDRESS
Henry Stock & Son	130 E Eager St

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53320 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53320

V

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Maryland Penitentiary ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Smith

(a) RESIDENCE. NO. La Plata, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Hd

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Charles County, Md.
(State or country)

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) La Plata
(State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Mary Hawkins

13 BIRTHPLACE OF MOTHER (city or town) La Plata
(State or country) Charles Co. Md.

14 Informant (Address) P. D. Murray Warden Md. Pen.

15 Filed 1921 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1921

17 I HEREBY CERTIFY, That I attended deceased from March-10, 1921, to April-27, 1921, that I last saw him alive on April 27, 1921, and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation - Anaemia
Emphysema

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. 1 mos. 26 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) William F. Schwartz, M. D.

1928, 1921 (Address) Maryland Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakhurst Cem.	Apr 30 1921
20 UNDERTAKER	ADDRESS
Pol Cole	Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R3 01921

Morgue

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53321 ✓ D 53321

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 N. Fulton Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Ambrose Ingram

(Residence in Baltimore: No. 1637 N. Fulton Ave St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 8 (Day), 1889 (Year)

7-AGE, 31 yrs. 9 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver for 23
(b) General nature of industry, business, or establishment in which employed (or employer): Standard Oil Co

9-BIRTHPLACE, (State or Country), Prince George Co. Md.

PARENTS.

10-NAME OF FATHER, John Ingram

11-BIRTHPLACE OF FATHER (State or Country), Howard Co. Md

12-MAIDEN NAME OF MOTHER Evelyn Nichols

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Ingram

(Address) 2722 Edmondson ave

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

PR 3 0 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1920, to Apr 28 1921, that I saw h im alive on Apr 28 1921, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

(Duration) 1 yrs. mos. ds.

(Signed) Homer E Hodd M. D.

4/28, 1921. (Address) 735 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, MAY 2 1921, 191...

20-UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS 1835 W. PRATT STREET. ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 53322

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital, Bay View. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bogos T. Barzankian

(a) RESIDENCE. No. 216 Hoffman St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 8 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Barzankian

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt.	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Turkey

PARENTS

10 NAME OF FATHER Tartacvor Barzankian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Turkey

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Turkey

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed APR 30 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1921 to April 27, 1921.
that I last saw him alive on April 27, 1921.
and that death occurred, on the date stated above, at 11:30 P.m.
The CAUSE OF DEATH* was as follows;

Myocardial insufficiency.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) H. Herman, M. D.

4/28/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL 4/30/1921

20 UNDERTAKER William Cook — ADDRESS 502 E Natt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53323

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53323

CERTIFICATE OF DEATH.

80-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. David S. Pope.

(a) RESIDENCE. No. 2005 McCulloh ST., WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Pope

6 DATE OF BIRTH (month, day, and year) March 28 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82.	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 680

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David S. Pope

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland,

12 MAIDEN NAME OF MOTHER Sarah R. Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Julian S. Jones
(Address) 40th St near Oak St

15 Filed ....., 19.....
Robert P. Harrison, Registrar
(Burial Permit Clerk)

R 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28, 19 21, to April 29, 19 21, that I last saw h.... alive on April 29, 19 21, and that death occurred, on the date stated above, at 1 15 p m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. H. Janssenbaum, M. D.

April 1921 (Address) U. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Cemetery	May 1st 1921
20 UNDERTAKER	ADDRESS
Henry Jenkins & Son	Orchard & McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53324

CERTIFICATE OF DEATH.

79 D 53324

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N. Parrish ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Richardson

(Residence in Baltimore: No. 411 N. Parrish St ST.; 56 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 11 (Day), 1865 (Year)

7-AGE, 56 yrs. 1 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, David Richardson

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Annie Halliday

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Richardson

(Address) 108 N. Bruce St

15-

Filed....., 191.....

Registrar.

Robert P. Harrison,
Burial Permit Clerk.

R 3 01921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 29 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 11 1921, to April 29 1921, that I saw h alive on April 28 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal Disease

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) 2 yrs. mos. ds.

(Signed) Jay G. McRae M. D.

4-29 1921 (Address) 739 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL May 2, 1921

20-UNDERTAKER Daniel Easton — ADDRESS 976 Eutaw

MAY be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53325

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53325

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 527 Eisler St ST.) 21 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Jenkins

(Residence in Baltimore: No. 527 Eisler St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, 4 (Month) 28 (Day), 14 (Year)

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ga,

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), / / /

12-MAIDEN NAME OF MOTHER / / /

13-BIRTHPLACE OF MOTHER (State or Country), / / /

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Taylor

(Address) 916 Dawes

15-

Filed....., 191.....

APR 30 1921

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know of any

(Duration) yrs. mos. ds.

(Signed) H. K. Gruich M. D. (Coroner.)

4p 30, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Dulaney Valley Cem. DATE OF BURIAL, May 1, 1921

20-UNDERTAKER Dan'l Taylor ADDRESS 916 Dawes

Robert P. Harrison,
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53326 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53326

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S. Wolfe St.: 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Bensel

(a) RESIDENCE. No. 410 S. Wolfe ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 26. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At home

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Conrad Bensel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Clement

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth R. Bensel
(Address) 410 S. Wolfe St.

15 Filed [illegible], 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1921

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1921, to April 28, 1921, that I last saw h[illegible] alive on " 28 1921, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. D. Heer, M. D.

, 19 (Address) 408 S. Pat. Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	May 1 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 East St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

83 01921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53327 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53327

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 725 S Dallas ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Blashky

(a) RESIDENCE. No. 725 S. Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Blashky

6 DATE OF BIRTH (month, day, and year) April 19-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Allgeier

(Address) 725 S. Dallas St

15 Filed ... 19 ... Registrar

Robert J. Harrison, Burial Permit Clerk.

PR3 01921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-25 , 1921, to 4-28 , 1921, that I last saw him alive on 4-27 , 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Asthma & Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & symptomatology

(Signed) Guy A Imbert , M. D.

4/28 1921 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cemetery	May 1 1921
20 UNDERTAKER	**ADDRESS**
H. Sander & Sons	1710 Fleet St.

TION is very important. See instructions on back of certificates.

(Parker)

D 53328

HEALTH DEPARTMENT—CITY OF BALTIMORE

156 D 53328

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1115 Eutaw St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Malinda Porter

(Residence in Baltimore: No. 1115 E. Eutaw Ave St.; 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (*Write* the word.) Widowed

6-DATE OF BIRTH, ... Jan (Month) 9 (Day), 1857 (Year)

7-AGE, 64 yrs. 3 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, William Webb

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virgie Bowles

(Address) 1017 E. Eutaw

15-

Robert F. Harrison,
Registrar and Ex-Officio Clerk

Filed....., 191.....
Registrar.

PR 3 01921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28 (Month) (Day), 1928 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by inhalation of illuminating gas

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Thomas Ryan Dorsey M. D. (Coroner.)

April 28, 192.. (Address) 1200 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel Cemetery	May 2, 1928
20-UNDERTAKER	ADDRESS
H. Sander & Son	1116 Flint St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53329

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Portugal St ST.: V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes C Roberts

(a) RESIDENCE. No. 2006 Portigal ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27th 1917

7 AGE — Years: 3 — Months: 6 — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Charles Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Cavon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mary Roberts

(Address): 2006 Portigal St

15 Filed ....., 19 ..... Registrar

PR 01921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15 , 1921 , to April 28 , 1921 , that I last saw her alive on April 27 , 1921 , and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis (Capillary)

(durntion) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary) /

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) John H. Rehberger , M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: April 29 1921

20 UNDERTAKER: Millard B Callender — ADDRESS: Bank & Ann Sts

Robt. P. Harrison, Registrar of Vital Records.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and those CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53330 HEALTH DEPARTMENT---CITY OF BALTIMORE D 53330

CERTIFICATE OF DEATH

91

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2001 Clifton ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvin T Usher

(Residence in Baltimore: No. 2001 W Clifton ave Balto St.; 1 yrs. " mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH: 5 (Month) 11 (Day), 1919 (Year)

7-AGE: 1 yrs. 11 mos. 17 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Balto Md.

PARENTS

10-NAME OF FATHER: Thomas A Usher

11-BIRTHPLACE OF FATHER (State or country): Balto Md.

12-MAIDEN NAME OF MOTHER: Butcher Carrie M.

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas A Usher

(Address) 2001 W Clifton Ave

15-

Filed 1-10-21, 191 REGISTRAR

Robert F. Harrison,
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 4 (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4-26, 1921, to, 4-28 1921, that I saw h..... alive on 4-28 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

(a) Meningitis Purulent

(Duration) ..... yrs ..... mos. 4 ds.

Contributory (SECONDARY) Cardiac Insufficiency

(Duration) ..... yrs ..... mos. 1 ds.

(Signed) Wm J Burgess M. D.

4-28, 1921 [Address] 1524 N Eutaw St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: April 30 1921

20-UNDERTAKER: Geo. J. Smith — ADDRESS: Fayette & Eutaw

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53331

D 53331

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Geo. T. Shaad

(a) RESIDENCE. NO. 834 Dover Street WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know

6 DATE OF BIRTH (month, day, and year): [illegible] 1850

7 AGE: Years 71 Months Do not know Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Do. not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Geo. T. Shaad
(Address) 1134 Dover St

15 Filed ... 19 ... Robert P. Harrison. Registrar

APR 30 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-27-1921

17 I HEREBY CERTIFY, That I attended deceased from 3-2, 1921, to 4-27, 1921, that I last saw h[illegible] alive on 4-27, 1921, and that death occurred, on the date stated above, at 2:45 m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis

Cardiac dilatation

(duration) Unknown yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) 1 yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) W. M. Craig, M. D.

, 19 (Address) St Agnes R.C.M.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 30/21
20 UNDERTAKER	ADDRESS
F. B. Tapport	223 Frederick Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Every statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53332 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53332

CERTIFICATE OF DEATH. X 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Laura Feagens

(a) RESIDENCE. NO. Laurel, Md ST., WARD. Laurel Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do-not-Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Do-not-Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. French (Address) Laurel Md

15 Filed 01921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1921

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1921, to April 30, 1921, that I last saw her alive on April 30, 1921, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? Yes Date of 4/26/21

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) M. F. Hartsumpaney, M. D.

, 19 (Address) Maryland Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	5/2/19
20 UNDERTAKER	ADDRESS
John J Fahey & Son	138 Eight

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53333 HEALTH DEPARTMENT—CITY OF BALTIMORE 091 D 53333

CERTIFICATE OF DEATH.

2

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 14 ST.: WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Hiram Brodie

(a) RESIDENCE. No. 2032 Eutaw Place ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 19 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Beauty Parlor

(c) Name of employer Hymens Beauty Parlor.

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Solomon Brodie

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Jane Walton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Harry S Block

(Address) 3603 Springfield Ave

15 Filed 19 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1921, to April 29, 1921, that I last saw him alive on April 29, 1921, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Typhus fever.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumonia Bronchial

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. E. W. Hardy, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Har Sinai Cemetery	May 1 1921
20 UNDERTAKER W. F. Tickner & Son	ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53334

D 53334

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 S. Wolfe St. ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Voith

(a) RESIDENCE. NO. 12 S. Wolfe St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Voith

6 DATE OF BIRTH (month, day, and year) March 4-1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Sebastian Protzman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Lautenbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anthony Voith (Address) 12 S. Wolfe St.

15 Filed Robert P. Harrison, Registrar

APR 8 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1921

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1921, to Apr. 28, 1921, that I last saw her alive on April 27, 1921, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectal sigmoid

(duration) — yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Mar. 7-1921

Was there an autopsy? No

What test confirmed diagnosis? The operation

(Signed) Edwin B. Jenby, M. D.

4/30/1921 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	May 2 1921
20 UNDERTAKER Lilly and Zuke	ADDRESS 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53335

CERTIFICATE OF DEATH.

64 D 53335

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 N. Enson. St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Bell Kennard.

(Residence in Baltimore: No. 708 N Enson St St. 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 6 (Month) (Day), 1868 (Year)

7-AGE, 53 yrs. 1 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Trained Nurse
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Live in Balt City 25 years Baltimore County

PARENTS.

10-NAME OF FATHER, John Schubert

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sarah Schubert

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Kennard

(Address) 708 N. Enson St.

15- MAY 1-1921 Filed, 191, Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 14 1921, to April 28 1921, that I saw h[illegible] alive on April 28 1921, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Coma and Exhaustion

(Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

April 30, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Lawn

DATE OF BURIAL, May 1, 1921.

20-UNDERTAKER Geo Robert A Elliott Laurel

ADDRESS 1133

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 53336

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 N. Potomac ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Virginia Riegel.

(a) RESIDENCE. No. 132 N. Potomac ST., 6 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George B. Riegel.

6 DATE OF BIRTH (month, day, and year) Oct. 24 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John G. Rutle.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary A. McGinn.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant George B. Riegel

(Address) 1825 E. Biddle St.

15 Filed MAY 1 - 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1921, to Apr 28, 1921, that I last saw h[illegible] alive on Apr 28, 1921, and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

[illegible] Chron. Mutrial Regurgitation

7

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Exam

(Signed) H. Kelly, M. D.

19 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	May 2nd 1921

20 UNDERTAKER Lilly - Zeiler

ADDRESS 400 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Obery Harrison

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53337

CERTIFICATE OF DEATH.

175-003 D 53337

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph Hospital St.; 5 WARD)
REGISTERED No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Obery Harrison.
(Residence in Baltimore: No. 1305 Lexington St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Mal
4-COLOR OR RACE: Col.
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Sgle

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 22 yrs. mos. ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9-BIRTHPLACE, (State or Country), Littleton N C
live in Baltimore 3 years

PARENTS.
10-NAME OF FATHER, Louis Harrison
11-BIRTHPLACE OF FATHER (State or Country), N C.
12-MAIDEN NAME OF MOTHER Laura Jackson
13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O B Harrison
(Address) 1305 E Lexington St

15- MAY 1 1921
Filed ..... 191.. Burial Permit Issued ..... 191..
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest on the body and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pneumonia one week
Mg R.N. organic Heart
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) J Ross Fowler M. D.
(Coroner.)
4-30, 1921 (Address) 19 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Littleton N C
DATE OF BURIAL, May 1, 1921
20-UNDERTAKER Mrs Robert A Elliott
ADDRESS 1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spew. 6-9-19—H. P. Co.—1000 Blks.

D 53338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53338

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 Whittier Ave ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Markell

(a) RESIDENCE. No. 2316 Whittier Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred at 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Wolf W. Markell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Markell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant John Markell

(Address) 2316 Whittier ave

15 MAY 1 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1921, to April 30, 1921, that I last saw her alive on April 30, 1921, and that death occurred, on the date stated above, at 12 15 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Toxemia - cardiac exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lentz, M. D.

4/30, 1921 (Address) 2006 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Blvd R.P.	May 1 1921
20 UNDERTAKER Jos Levinson	ADDRESS 427 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 53339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53339

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Brewer

(a) RESIDENCE. No. 212 Glasgow St. ST. WARD. Portsmouth Va

(Usual place of abode) Portsmouth, Va.

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Benj. Brewer

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Ida Rosenhoff

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed MAY 1 1921 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17

I HEREBY CERTIFY, That I attended deceased from April 18 1921 to April 29 1921, that I last saw h alive on April 29 1921, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Brain Tumor
Hypophysis
(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W E Dandy, M. D.

4-29-21 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Belair Rd.	April 29 1921
20 UNDERTAKER Mary Lennon	ADDRESS 1127 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53340

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53340

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Strauss

(a) RESIDENCE. No. 2803 Walbrook Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 69 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Strauss

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Russian Store

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Abeshon Strauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Philip Strouse

(Address) 2803 Walbrook Ave

15 Filed MAY 1 - 1921 ROBERT E KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-28, 1921, to 4-30, 1921, that I last saw him alive on 4-30, 1921, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Septicemia following infection of leg

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-27-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. V. Hooper M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	May 2 1921
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53341

CERTIFICATE OF DEATH.

5-79 D 53341

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Hebrew aged Home ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Sachs

(Residence in Baltimore: No. 111 Aisquith Street St.; 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown ....., 18.0
(Month) (Day) (Year)

7-AGE, 81 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Refuge Home

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. J. Sachs

(Address) 1102 Westwood Ave

15- Filed MAY 1-1921 AGNES E KRAUTER Clerk
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to April 25 1921, that I saw her alive on April 25 1921, and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Arterio Sclerosis (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism

..... (Duration) yrs. mos. ds.

(Signed) M J Baylus M. D.

4/30, 1921. (Address) 210 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 11 mos. ds. In the State 14 yrs. mos. ds.

Where was disease contracted, if not at place of death? Loyed Madison St

Former or usual residence 1102 Westwood Ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Cemetery DATE OF BURIAL, May 1, 1921.

20-UNDERTAKER Jack Leary ADDRESS 1411 E Baltimore St

CAUSE OF DEATH must be plainly and properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 53342

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53342

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Erdman Hill Bel air ~~Road~~ ST.: 26 WARD)

2-FULL NAME John G. Erdman

(a) RESIDENCE. No. Erdman Hill Bel air Road ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 1 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Christianna M Erdman

6 DATE OF BIRTH (month, day, and year) Mch 8th 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Truck Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam B. Erdman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Catherine Houser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant George B. Erdman

(Address) 3401 Belair Road

15 Filed MAY 1 — 1921 ASHBY A KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from June 10th 1921 to April 29th 1921, that I last saw h in alive on April 29th 1921, and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert S. Kirk M. D.

Apl 30th 1921 (Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	May 2nd 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53343

CERTIFICATE OF DEATH.

64

D 53343

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 N Caroline St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Shaw

(a) RESIDENCE. No. 818 N Caroline St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Henry Shaw.

6 DATE OF BIRTH (month, day, and year) Sept. 26 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	~~11~~	743 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel Dungley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ellen April

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Harry Shaw.
(Address) 818 N Caroline.

15 Filed MAY 1 1921 ASHLEY I. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17 I HEREBY CERTIFY, That I attended deceased from March 12 1921, to April 29 1921, that I last saw h[illegible] alive on April 26 21, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Cirr.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What ~~test confirmed~~ diagnosis?

(Signed) O Stone, M. D.

1921 (Address) 150 E Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	May 2 1921
20 UNDERTAKER	ADDRESS
Wm Cook & Son	E Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53344

CERTIFICATE OF DEATH.

Gr D 53344

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 129 N. Fulton St.; 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Shea

(a) RESIDENCE. No. 129 N. Fulton St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower Wm E. Shea

6 DATE OF BIRTH (month, day, and year) — — 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Dont Know
(State or country) Dont Know

PARENTS

10 NAME OF FATHER Hogan

11 BIRTHPLACE OF FATHER (city or town) Dont Know
(State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country) Dont Know

14 Informant Mrs Edwin F. Ebbutt
(Address) 2122 Fenwick ave

15 Filed MAY 1 - 1921 19 JOSEPH J. KLAUTER Registrar
Burial Permit Oiced

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1921

17 I HEREBY CERTIFY, That I attended deceased from April 23, 19 21, to April 29, 19 21, that I last saw h... alive on April 29, 19 21, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

Arteriosclerosis

Dilatation of heart

(duration) ...yrs 1 mos. 8 ds.

CONTRIBUTORY (Secondary) ...

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Edw V Coleman, M. D.

, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 2 1921
20 UNDERTAKER	ADDRESS
Geo Weber & Son	2503 Edmondson ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53345

CERTIFICATE OF DEATH.

91

D 53345

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 Poplar Grove St.: 16 WARD)

2-FULL NAME Beatrice Beverly Brown

(a) RESIDENCE. No. 746 Poplar Grove ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. 3 mos. 5 ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 746 Poplar Grove Baltimore Md

PARENTS

10 NAME OF FATHER Clarence Brown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Grace M. Meeks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Md

14 Informant Clarence Brown
(Address) 746 Poplar Grove

15 Filed MAY 1 - 1921 ROBERT I. GRAFTON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1921

17

I HEREBY CERTIFY, That I attended deceased from April 30, 1921, to April 30, 1921, that I last saw h[illegible] alive on April 30, 1921, and that death occurred, on the date stated above, at 4.15 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia with

Convulsions (3hrs)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis (about 2 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E. Erickenson, M. D.

April 30, 1921 (Address) 2002 N. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine	May 2 1921
20 UNDERTAKER Geo W Little	ADDRESS 2100 Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53346

HEALTH DEPARTMENT—CITY OF BALTIMORE

102

D 53346

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. F. Brooks.

(a) RESIDENCE. NO. 913 W. Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) February 26, 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46 yrs.	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Benjamin F. Brooks

11 BIRTHPLACE OF FATHER (city or town) "

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia A. Wood

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md

(State or country)

14 Informant Charles B. F. Brooks

(Address) Pasadena Md

15 MAY 1 - 1921 Filed ..., 19.. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-27, 1921, to 4-29, 1921, that I last saw h-me alive on 4-29, 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Gastric haemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Winfield M. Craig M. D.

4-30, 1921 (Address) St Agnes R.T.M.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 2 1921
20 UNDERTAKER	ADDRESS
Geo W Little	2700 Edmondson av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53347

D 53347

CERTIFICATE OF DEATH.

REGISTERED NO. 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1548 Mowdyear ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elenora E. Aird

(a) RESIDENCE. No. 1548 Mowdyear ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hester Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James H Dennis
(Address) 1303 Prestman

15 Filed MAY 1 - 1921, 19 ... ROLLA E. BRADY Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/29/ 1921

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1921, to April 29, 1921, that I last saw h.. alive on April 29, 1921, and that death occurred, on the date stated above, at 4:20 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 7

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) Edward J. Wheatley, M. D.

1921 (Address) 1231 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leakeysville Md	MAY 2 1921

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53348

CERTIFICATE OF DEATH.

105 D 53348

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1015 N. Calhoun ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Albert Dennis

(Residence in Baltimore: No. 1015 N. Calhoun St.; 3 yrs., — mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Male	colored	single

6-DATE OF BIRTH, March (Month) 3 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
3 yrs. 1 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... child

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Walter Dennis

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Martha L. Siefert

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Dennis

(Address) 1015 N. Calhoun St.

15-MAY 1-1921 Filed....., 191... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said held (Inquest, autopsy or inquiry) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(36 hrs.)

(Duration)..... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) see history

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) J. H. Hennessy M. D. (Coroner.)

April 29 1921 (Address) 2502 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, MAY 1 1921

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53349

CERTIFICATE OF DEATH.

4 × 122

1-PLACE OF DEATH University Hospital.

REGISTERED NO.....

CITY OF BALTIMORE: (No. Lombard & Green Sts. ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Minerva Fonwood

(a) RESIDENCE. No. Idlewilde-Towson, ST.; ..... WARD. Idlewilde Towson

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35,			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Pearce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Fannie Lytle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Joseph Pearce
(Address) White Hall Md

15 MAY 1 - 1921 ROBERT J. BRAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-26 ....., 1921, to 5-1- ....., 1921,

that I last saw her alive on 4-30- ....., 1921,

and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Shock fol. Nephrotomy,

Over

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? YES. Date of 4-30-21

Was there an autopsy? no,

What test confirmed diagnosis?

(Signed) J. M. Hundley Jr., M. D.

, 19 (Address) University Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Vernon Cemetery	May 4 1921
20 UNDERTAKER	ADDRESS
P. Marklin & Son	White Hall Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for cyst of kidney

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D 53350

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 53350

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 W. Lee ST.: 7W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Smith

(a) RESIDENCE. No. 510 W. Lee ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Smith

6 DATE OF BIRTH (month, day, and year) [illegible] 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ficha Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Rachel Smith

(Address) 510 W Lee St

15 [illegible] MAY 1-1921 ROBERT P. BRAUNE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1921

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 29, 1921, that I last saw h[illegible] alive on April 29, 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) W. Flowers, M. D.

1921 (Address) 1129 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mandaw Wlf. Aconac Co. Va	May 3 1921
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53351

CERTIFICATE OF DEATH.

28 D 53351

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Mosher ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James. F. Lee

(a) RESIDENCE NO. 1923 Mosher 1 ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. c mos. c ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	white	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Lee

6 DATE OF BIRTH (month, day, and year) Dec 24 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	4	c	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(h) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Humphrey W. Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Farthing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Margaret A. Lee

(Address) 1923 Mosher St

15 MAY 1 - 1921 ROBERT B KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1921

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1921, to April 30, 1921, that I last saw h- alive on April 30, 1921, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. C. Shannon, M. D.

4/30 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 2 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	217 S. Para

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy." "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Pulmonary Tuberculosis

D 53352

Spec. 6-9-19 H. P. Co.—1000 Bks.

53352 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53352

CERTIFICATE OF DEATH.

REGISTERED NO. 77

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2803 W. North ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME B. Frank. Andrews.

(a) RESIDENCE. No. 2803 W. North ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city ~~or town~~) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Andrews

11 BIRTHPLACE OF FATHER (city ~~or town~~) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Daley

13 BIRTHPLACE OF MOTHER (city ~~or town~~) (State or ~~country~~) Baltimore Md

14 Informant H. Andrews

(Address) 2803 W North Ave

15 Filed MAY 2 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to April 29, 1921, that I last saw him alive on April 29, 1921, and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

1 Pneumonia

Acute Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Cullen M. D.

4:30 P. M. (Address) 2757 W North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	May 2 1921
20 UNDERTAKER	ADDRESS
Martin Daley & Son	2279 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53353 HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 53353

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Register,

(a) RESIDENCE. No. Preston & Valley Sts. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sandford Co.

PARENTS

10 NAME OF FATHER Elizar Register

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sister Florence

(Address) Preston & Valley Sts

15 MAY 2 - 1921 ROBERT [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...,

that I last saw him alive on April 27, 1921,

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F A Warner, M. D.

April 30, 1921 (Address) 1193 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 2 1921

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 53354

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. New Howard Hotel Balto m St ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Conway

(Residence in Baltimore: No. New Howard Hotel St.; yrs., (one) mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Dont Know

6-DATE OF BIRTH, Dont Know (Month) , 1 (Day) (Year)

7-AGE, 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Dont Know
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, Dont Kobow

11-BIRTHPLACE OF FATHER (State or Country), Dont Kobow

12-MAIDEN NAME OF MOTHER Dont Kobow

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pat Johnson

(Address) 126 Eastern ave.

15-MAY 2 - 1921

Filed....., 191.... ROBERT J. CRAUTER

Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.)

thereon and from the evidence obtained by said ~~(Inquest, au-~~ topsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broken Neck Broken Leg & Internal injuries

(Duration) a few mins. yrs. mos. ds.

CONTRIBUTORY (Secondary) fell while going on Elevator

Clerk New Howard Hotel (Duration) yrs. mos. ds.

(Signed) H. K. Grossmann M. D. (Coroner.)

Apr 25, 1921. (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Trinity Cemetery

DATE OF BURIAL, 5/25/21, 19....

20-UNDERTAKER George J. Kelly

ADDRESS 1735 Harford ave

MAY 2. 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+5 D 53355

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Spring Hill Terrace ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Ringgold

(a) RESIDENCE. NO. 701 Spring Hill Terrace ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose S. Ringgold

6 DATE OF BIRTH (month, day, and year) 1857-Feb-2

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John P. Ringgold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise A. Wickes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Rose S. Ringgold

(Address) 701 Spring Hill Terrace

15 Filed MAY 2 - 1921 19 ROBERT L. KRAUTH Registrar

Burial Permit 51688

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. , 1921, to April 30, 1921,

that I last saw him alive on April 30 1921,

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? clinical & X Ray

(Signed) I Frederick Lutz, M. D.

5/1, 1921 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Govans	May 3, 1921
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmount Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Hattie A E. Fisher

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53356

CERTIFICATE OF DEATH.

37

~D 53356

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1134 N. Stricker ST. (WARD) 17

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie A. E. Fisher

(Residence in Baltimore: No. 513 Stricker St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, March 30 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Wm Fisher

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Minnie Gilbert

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Fisher

(Address) 513 Stricker St

15-
Filed MAY 2 - 1921, 191...
ROBERT E BEAUTER
Burial Permit Received

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1st, 1921
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from April 27th, 1921, to May 1st, 1921, that I saw h[illegible] alive on April 30th, 1921, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows: Congenital Lues

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. .... mos. ....ds.

(Signed) A. Fre. Ellis M. D.

May 1, 1921 (Address) 92 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, May 3, 1921

20-UNDERTAKER John H Goodwin

ADDRESS 142 White St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Ritzel

D 53357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53357

CERTIFICATE OF DEATH.

REGISTERED No. C 479

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 7 N. Frederick ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Ritzel

(Residence in Baltimore: No. 419 N. Washington St.; yrs., 55 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 29, 1866
(Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, C. Ritzel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Ritzel

(Address) 419 N. Washington

15-

Filed MAY 2 - 1921, 191.

SOMERS & KRAUTER
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, thereon and from the evidence obtained by said Inquest, found that said deceased came to death on the day stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

April 30, 1921. (Address) 1039 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel County — DATE OF BURIAL, May 2, 1921

20-UNDERTAKER Lee Lumbard & Son — ADDRESS 1470 Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIAN should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D 53358

REGISTERED NO.

1-PLACE OF DEATH Eastern

CITY OF BALTIMORE: (No. 755 Iceland ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Turner

(a) RESIDENCE. No. 755 Iceland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred abt 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nemiah Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Woods (Address) 736 Eastern Ave

15 Filed MAY 2 - 1921 ROBERT I. REMUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to April 29, 1921, that I last saw h~~im~~ alive on April 29, 1921, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Diseases Valvular

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) A. N. Florence M. D.

19 21 (Address) 712 E. Mary's Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 3 19 21
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	10 W. Mad

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 53359
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 519 W. Cross St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Davis. (C)

(Residence in Baltimore: No. 519 W. Cross St.

40 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored,	Married.

6-DATE OF BIRTH, January 1st. 1865 (Month) (Day), 1 (Year)

7-AGE, 56 yrs. 8 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Kent Co. Md.

PARENTS.

10-NAME OF FATHER, William W. Baynard (C)

11-BIRTHPLACE OF FATHER (State or Country), Kent Co. Md.

12-MAIDEN NAME OF MOTHER Emma. ---------- (C)

13-BIRTHPLACE OF MOTHER (State or Country), Kent Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Wright (C) daughter.

(Address) 519 W. Cross St.

15- ROBERT J. BRAUTER
Filed MAY 2 - 1921 191... Burial permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29th. 1921. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) Abel Reinhardt M. D.
(Coroner.)

Apl. 29 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	May 2., 1921
20-UNDERTAKER	ADDRESS
J L Brown & Son	108 monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53360

CERTIFICATE OF DEATH.

X 105 D 53360

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View. 36 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Freeland

(a) RESIDENCE. NO. Bay View Asylum ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred — yrs. 6 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Edward H. Freeland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Forbus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed MAY 2-1921 Burial Permit Issued by ROBERT A. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1921, to April 28, 1921, that I last saw him alive on April 28, 1921, and that death occurred, on the date stated above, at 2:35 P. m.

The CAUSE OF DEATH* was as follows:

Ulcerative colitis.
(etiology undetermined)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Retroperitoneal abscess (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) C. B. Heaman, M. D.

4/29/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Noture of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	5/2 1921
20 UNDERTAKER	ADDRESS
Chas. P. Evans & Son	1816 N. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53361

D 53361

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 N. Calhoun ST.: 19 WARD)

2-FULL NAME Katharine Vaupel

(a) RESIDENCE. No. 318 N. Calhoun ST., 19 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Vaupel

6 DATE OF BIRTH (month, day, and year) Jan 1 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \

(b) General nature of industry, business, or establishment in which employed (or employer) \

(c) Name of employer \

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo. Schoppach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John G. Vaupel
(Address) 302 N Calhoun

15 Filed . 19 ROBERT E KRAUTER Registrar
MAY 2 - 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29th 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 17 . 1921 , to April 28th , 1921 ,
that I last saw h[illegible] alive on april 28th , 1921 ,
and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Heart Failure (Sudden)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Carcin

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Marshall G. Smith M. D.

5-1. 1921 (Address) 11 N Calhoun st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	May 2 1921
20 UNDERTAKER	ADDRESS
F. A. Tranner & Son	1832 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Arteriosclerosis —
No haemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53362

CERTIFICATE OF DEATH.

79 D 53362

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. S.W. Cor. Franklin & Fulton St. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Kelly.

(a) RESIDENCE. No. Home for the Aged of the M E Church ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Lifetime mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 23-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 600

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer None. Baltimore Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry C. R. Kelly

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Kersh

13 BIRTHPLACE OF MOTHER (city or town) Penna (State or country)

14 Informant Etta Cuddy (Address) 400 N. Fulton Ave.

15 Filed MAY 2-1921 ROBERT P. LETOTE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30. 1921

17

I HEREBY CERTIFY, That I attended deceased from Jany 1, 1921, to April 30, 1921.

That I last saw h[e]r alive on April 26, 1921,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 4 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ✓ yrs. 2 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) George C. Shannon, M. D.

4/30 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 2, 1921
20 UNDERTAKER George J. Smith	ADDRESS 1000 N. Forest St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53363

CERTIFICATE OF DEATH.

29 ✓ D 53363

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 572 Oxford ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence E. Johnson

(Residence in Baltimore: No. 572 Oxford St. Fifth yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 18 (Day), 1876 (Year)

7-AGE, 44 yrs. 5 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Fred. Miles

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Johnson

(Address) 572 Oxford

15- FILED MAY 2 - 1921, 191.... ROBERT F. KRAUTER (Clerk) Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 20 1921, to Apr 30 1921, that I saw her alive on Apr 30 1921, and that death occurred, on the date stated above, at 8 16 m.

The CAUSE OF DEATH* was as follows:

1 Typhoid Pneumonia

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Organic Heart Mitral disease

(Duration) ....yrs. ....mos. ....ds.

(Signed) William E Burton M. D.

Apr 30, 1921 (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cmty — DATE OF BURIAL, May 3 1921

20-UNDERTAKER George H. Holland — ADDRESS 1632 Mills Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53364

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1828 D 53364

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 821 Bon alley ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgiana Cornick Moore

(Residence in Baltimore: No. 821 Bonn alley St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 9, 1887 (Month) (Day) (Year)

7-AGE, 33 yrs. 5 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE, (State or Country), Ind

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Moore

(Address) 821 Bonn Alley

15- MAY 2 - 1921 ROBERT F. KROUTER

Filed ....., 191.. Registrar. Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 11 1921, to April 29 1921, that I saw h e alive on Apr 28 1921, and that death occurred, on the date stated above, at 10.30a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

3 yrs mo to my personal knowledge (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ex Intoxication

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Stuyhoe M. D.

4/30, 1921 (Address) 765 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, May 2 1921.

20-UNDERTAKER George A. Gibson ADDRESS 513 Fauquier

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53365

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 D 53365

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3405 Springdale ave. WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret R. Lotz

(Residence in Baltimore: No. 54 Garrison Lane St.: 64 yrs. 3 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Jan 8th, 1857 (Month) (Day) (Year)

7-AGE: 64 yrs. 3 mos. 21 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Paul Hauck

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Philip Katz Jr.

(Address) 54 Garrison Lane

15-Filed MAY 2 - 1921 ROBERT B KRAUTER REGISTRAR

Burial Permit Issued

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 29 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1921, to April 29 1921, that I saw her alive on April 28, 1921, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Secondary carcinoma of Liver & Intestines

(Duration) ... yrs. 2 mos. 15 ds

Contributory (SECONDARY) Exhaustion

(Duration) ... yrs. ... mos. ... ds.

(Signed), L. Buck Joyce M. D.

May 1, 1921 (Address) 1 Hoop W. Northern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May 2, 1921

20-UNDERTAKER: F. B. Wagner

ADDRESS: 2236 Fredrick Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53366

CERTIFICATE OF DEATH.

150 D 53366

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 630 W. Cross ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Cross

(a) RESIDENCE. NO. 630 W. Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James J. Cross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: James J. Cross
(Address): 636 W. Cross St.

15 Filed MAY 2 - 1921 ROBERT P. BRADEN Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1921, to May 1, 1921, that I last saw her alive on May 1, 1921, and that death occurred, on the date stated above, at 8.10 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ✓

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm. O'Neill M. D.

5/2 1921 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 2 1921
20 UNDERTAKER	ADDRESS
James F. Dignan & Son	1000 S. Rose St.

NATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53367

CERTIFICATE OF DEATH.

10-6 D 53367

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N Port St ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Lisec (Lisec)

(Residence in Baltimore: No. 517 N Port St St.; 35 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Aug't 18, 1841
(Month) (Day) (Year)

7-AGE, 80 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Lisec

(Address) 415 N. Dunken St

15- MAY 2 - 1921 ROBERT P. PRATTER Registrar.
Filed....., 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 30, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1921, to April 30 1921, that I saw her alive on April 29 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

La Grippe

..... (Duration).....yrs.....mos. 2 8 ds.

CONTRIBUTORY (Secondary) Bronchitis & Exhaustion

..... (Duration).....yrs.....mos. 1 0 ds.

(Signed) Adolph Co. Eisenberg M. D.

April 30 1921 (Address) 220 E. Pleasant St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	May 3. 1921
20-UNDERTAKER	ADDRESS
Philip Herwig	2016 Orleans St.

Important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53368

CERTIFICATE OF DEATH.

1 104 W

REGISTERED NO. D 53368

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 410 S. Register St. St.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Duda

(Residence in Baltimore: No. 410 S. Register St. St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
nn Female	White	

6-DATE OF BIRTH, August 23/20, 1
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Peter Duda

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Amiela Kortkowski

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Duda

(Address) 410 S. Register St.

15- ROBERT J. KRAUTER

Filed MAY 2 - 1921 191.... Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 30/21, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Ilecolitis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

5/1/..., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	May 2/21, 19...
20-UNDERTAKER	ADDRESS
Wm. Fialkowski	1608 Eastern

D 53369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53369

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1611½ Brunt ST.: 14 WARD) 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. James Neal

(Residence in Baltimore: No. 1611½ Brunt St.: 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	widower

6-DATE OF BIRTH, November (Month) 7 (Day) 1856 (Year)

7-AGE,	If LESS than 1 day,
65 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: conductor
(b) General nature of industry, business, or establishment in which employed (or employer): (Labor) O.D.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Neal

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Ann Briscoe

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Thomas

(Address) 112 E Eutaw St.

15- Filed MAY 2 1921, 191.. REGISTRAR.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 29, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. E. Hemsley M. D. (Coroner)

April 30, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, May 1, 1921

20-UNDERTAKER Samuel J. Hemsley ADDRESS 3 B. Mt. Belle

N. B. Every item of information should be carefully applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53370

CERTIFICATE OF DEATH.

D 53370

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 24 WARD) 30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Colwell

(a) RESIDENCE. NO. US. Public Health Hosp. #56 Fort McHenry Baltimore Md. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	36 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer: -----

9 BIRTHPLACE (city or town) (State or country): Ill.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Edgar T Rosenbrock Registrar

(Address) US. PHS Hosp. #56 Ft McHenry Md.

15 MAY 2-1921 ROBERT J. KRAUTHEIM Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1921

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to April 30, 1921,

that I last saw him alive on April 30, 1921,

and that death occurred, on the date stated above, at 11'45 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary (active)

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam. Lab. report.

(Signed) Thomas B. Payne, Senior Surgeon (M.R.)D.

, 19 (Address) US. PHS Hosp. #56 Ft. McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
San Francisco Cal	May 2 1921
20 UNDERTAKER	ADDRESS
A. Leinson & Bro	E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53371

CERTIFICATE OF DEATH.

40

D 53371

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 N. Calvert ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James William Johnson

(a) RESIDENCE. No. 2213 N. Calvert ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Georgia Le Grand

6 DATE OF BIRTH (month, day, and year): June 5, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): St. Mary's Co. Maryland

PARENTS

10 NAME OF FATHER: Joseph S. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Mary's Maryland

12 MAIDEN NAME OF MOTHER: Eliza Mattingly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. George Johnson
(Address): 2213 N. Calvert Street

15 Filed MAY 2 - 1921 [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 30th 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr 3rd, 1921, to Apr 30th, 1921, that I last saw him alive on Apr 30th, 1921, and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) Leonard Wm C. Parker, M. D.

May 7, 1921 (Address) 1114 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	5/3 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53372 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53372

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 Ashland Ave ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Harryman

(a) RESIDENCE. No. 617 Ashland Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Harryman

6 DATE OF BIRTH (month, day, and year) Dec 10 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Wm W.R. Harryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Fannie Mackie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Margaret Harryman (Address) 617 Ashland Ave

15 MAY 2 - 1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1921

17 I HEREBY CERTIFY, that I attended deceased from February 21 19.. to April 29 19 21

that I last saw h.. alive on April 29 19 21

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Meyer, M. D.

4/30 19 21 Address 10 E. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	May 3 1921
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son,	811 N. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53373

CERTIFICATE OF DEATH.

D 53373

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 N. Mount ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lucinda Valentine

(a) RESIDENCE. NO. 1409 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. Alfred Valentine

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) Smithfield, Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Wm. A. Valentine
(Address) 1409 N. Mount St

15 FILED MAY 2 - 1921 ROBERT J. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 19 21

17 I HEREBY CERTIFY, That I attended deceased from 3.45 P.M. April 28 19 21, to 11.20 P.M. April 28 19 21, that I last saw h... alive on April 28, 11.20 P.M. 19 21, and that death occurred, on the date stated above, at 11.20 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis & Cerebral Hemorrhage

one

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute enteritis & Toxic amblyopia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sign and Symptoms

(Signed) Wm. E. J. Carey, M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 2 19
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53374

CERTIFICATE OF DEATH.

151 D 53374

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 740 N Redwood ST.: 4 WARD)

2-FULL NAME Baby Catherine Carter

(a) RESIDENCE. NO. 740 N Redwood ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Bretwood Maryland

PARENTS

10 NAME OF FATHER James Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Maryland

12 MAIDEN NAME OF MOTHER Clara Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lottsburg Virginia

14 Informant Clara Carter mother
(Address) 740 N Redwood St

15 MAY 2 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17

I HEREBY CERTIFY, That I attended deceased from April 27, 1921, to May 2, 1921, that I last saw her alive on May 1, 1921, and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Prematurity
(34 wks fetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Illoris Rice, M. D.

5-2, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St Peters Cemetery May 2 1921

20 UNDERTAKER — ADDRESS

Mrs Gobbitzer 406 W Conway St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 53375

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 N Bond ST.: 6 WARD)

2-FULL NAME Helen Hill

(a) RESIDENCE. No. 208 N. Bond ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Col	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		Six	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Fleming Hill

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Scott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Sarah Hill
(Address) 208 N Bond

15 Filed MAY 2 - 1921 ROBERT A. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1921

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1921, to May 1, 1921, that I last saw h.. alive on April 30, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) W. C. Burns, M. D.

1921 (Address) 2218 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	May 3 1921

20 UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—8-24-14—M. & T.—2000 Bks.

D 53376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53376

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 W Lafayette ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith L. Johnson

(Residence in Baltimore: No. 540 W. Lafayette Av St.; 2½ yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	single

6-DATE OF BIRTH, Oct 10 (Month), (Day), 1918 (Year)

7-AGE, 2 yrs. 6 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William F Johnson

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Hattie Archer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Johnson

(Address) 540 W Lafayette Ave

15- Filed MAY 2 - 1921, 191... ROBERT J. BRUTON Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 30, 1921, 191... (Month), (Day), (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 29 1921, to Apr 30 1921, that I saw h[illegible] alive on Apr 30 1921, and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 2 ds. 3

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ½ ds.

(Signed) H. P. Hughes, M. D.

4/30/21, 191... (Address) 765 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	May 3., 1921
20-UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53377 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53377

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 Dell ST.: 24 WARD)

2-FULL NAME Wilhelmina Abram

(a) RESIDENCE. NO. 1702 Dell ST., WARD. 24

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? 16 yrs. 8 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8.24.1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
16	16	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Czelis Bary Aust Co Pol.

PARENTS

10 NAME OF FATHER Adolph Abram

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Annie Dows

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant (Address) Adolph Abram 1702 Dell Pl.

15 Filed MAY 2 - 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5.1 1921

17 I HEREBY CERTIFY, That I attended deceased from 3.20, 1921, to 5.1, 1921, that I last saw h[illegible] alive on 5.1, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

(Primary) Chronic Endocarditis of Heart

From History (duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) G J Durlington, M. D.

, 19 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	5/4 1921
20 UNDERTAKER	ADDRESS
I. Few McCully	130 E Fort

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Full statement of OCCUPATION is very important. See instructions on back of certificates.

D 53378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1794 D 53378

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Montreal Apts. 13 E. Mt. Royal Av. St.; 11 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Newton Wheatley

(Residence in Baltimore: No. Belvoir Apts St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, April 3-1891, 1
(Month) (Day) (Year)

7-AGE, 30 yrs. mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tutor
(b) General nature of industry, business, or establishment in which employed (or employer): 18

9-BIRTHPLACE, (State or Country), Danville, Va.

PARENTS.

10-NAME OF FATHER, Ford H. Wheatley

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Elizabeth Farbour

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph E. Wheatley

(Address) 513-9th N.E. Washington, D.C.

15-

Filed ..... 191.... Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Caused by heavy timber accidentally
Crushed by an elevator in
Montreal apts.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. L. Riley (Coroner.) M. D.

May 2, 1921. (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. Few hours. ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Belvedere Hotel

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Danville, Va.	5/2/1921, 19....
20-UNDERTAKER C.E. Evans & Son	ADDRESS 116 W. Mt. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MY 2 - 1921 Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53379

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53379

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 N. Eden St. ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Plantholt

(a) RESIDENCE. NO. 1116 N Eden St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, 16 hrs. or ... min.
		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Plantholt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mildert Frederick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Henry Plantholt
(Address) 1116 N Eden St

15 Filed ..... 19 Robert P. Harrison Registrar

MAY 2 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 1921, to May 2, 1921, that I last saw h... alive on May 1 2, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

16 hr.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Fineler, M. D.

, 19 (Address) 1706 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 2 1921
20 UNDERTAKER	ADDRESS
Henry Koeck & Son	1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53380 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53380

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2062 E. Eager St.: 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Grevelding

(a) RESIDENCE. No. 2062 E Eager St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Grevelding.

6 DATE OF BIRTH (month, day, and year) March 21 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Nicholas Thome

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Barbara Schlagintoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Barbara Francis
(Address) 2062 E Eager St

15 Filed ..... 19.. Robert P. Harrison Registrar

MAY 2-1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1921

I HEREBY CERTIFY, That I attended deceased from June 15 = 20 May 1 = 21, 19.., to ..., 19.., that I last saw h... alive on April 30 = 21, 19.., and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) ... yrs. 10 mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What ... confirmed diagnosis? Clinical

(Signed) E. A. Magruder M. D.

May 2, 19 21 (Address) 1031 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 4 1921
20 UNDERTAKER	ADDRESS
Henry Storck Son	1301 E Eager St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53381

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53381

92

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Ashland Ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Rassa

(a) RESIDENCE. NO. 1404 Ashland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? 57 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE of~~ Frances Rassa

6 DATE OF BIRTH (month, day, and year) Dec. 15 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Wheelright

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Frances Rassa
(Address) 1404 Ashland ave.

15 Filed ..... Robert P. Harrison, Registrar
MAY 2 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1921, to May 1, 1921, that I last saw him alive on April 30, 1921, and that death occurred, on the date stated above, at 4 1/2 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....(duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) .....(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Jacob Frisch, M. D.

May 1. 1921 (Address) 1823 N. Wast St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 4 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53382

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 53382

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 N. Bradford ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel T. Bourke

(a) RESIDENCE. No. 1720 N. Bradford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ the late Elizabeth Bourke

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman at

(b) General nature of industry, business, or establishment in which employed (or employer) Ship yard.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER Samuel T. Bourke

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co. Md

12 MAIDEN NAME OF MOTHER Mary Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Margaret Roberman
(Address) 1720 N Bradford St

15 Filed ... 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from April 20 1921, to May 2. 1921, that I last saw h[illegible] alive on May 2 1921, and that death occurred, on the date stated above, at 8.10 A.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia.
(Apoplexy)
Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. Blood Pres. Obs.

What test confirmed diagnosis?

(Signed) Edward E Lambert, M. D.

May 3 1921 (Address) 928 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cemetery	May 4 1921
20 UNDERTAKER	ADDRESS
Henry Woerle & Son	1311 E Eager St

MAY 2-1921 Burial Permit Clerk.

TION is very important. See instructions on back of certificates.

D 53383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53383

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore General Hospital. REGISTERED No. C 175-04

CITY OF BALTIMORE (No. 3 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Abramowitz.

(Residence in Baltimore: No. 811 E. Baltimore St. 2 -- 4 -- 2. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, December 29th, 1918., 1 (Month) (Day) (Year)

7-AGE, 2 yrs. 4 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. Louis Abramowitz.

11-BIRTHPLACE OF FATHER (State or Country), Russia.

12-MAIDEN NAME OF MOTHER Rose Greenberg.

13-BIRTHPLACE OF MOTHER (State or Country), Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Abramowitz. (father).

(Address) 811 E. Baltimore Street

15- Robert P. Harrison,

Filed MAY 2-1921, 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1st, 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally run over by car #4012 of U. Ry & E Co. Leg Crushed and ambutated.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) ....yrs....mos....ds.

(Signed) Otto C. Weinhardt M. D. (Coroner.)

May 2nd., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Accident April 27th, 1921. Leadenhall and Hamburg Sts.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Filbert Mordell. DATE OF BURIAL, May 3, 1921.

20-UNDERTAKER Jack Levi. ADDRESS ~~May 3-1921~~ 1411 E. Pratt St.

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

147184 D 53384

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53384 ✓

CERTIFICATE OF DEATH.

9

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Wiedemer.

(a) RESIDENCE. No. 705 Gorsuch Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. Life How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~late~~ ~~WIFE of~~ Mrs. Rose Wiedemer. (Mother)

6 DATE OF BIRTH (month, day, and year) Jan. 18, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edw. Wiedemar.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Rose Stadtmueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed ..... 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1921

17 I HEREBY CERTIFY, That I attended deceased from March 29 1921 to May 1 1921 that I last saw her alive on May 1 1921 and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. 3 mos. 13 ds.

CONTRIBUTORY (Secondary) Nasal Diphtheria

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Wassermann & Culture

(Signed) Horton Casparis, M. D.

5-2-21 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Forest Lawn	5/2/21
20 UNDERTAKER	ADDRESS
E. A. Wiedefeld Jr.	501 E 22nd

May 2 1921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53385

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Raphael's Home.

REGISTERED No. C 79

CITY OF BALTIMORE (No. 509 Hanover Street. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Herr.

(Residence in Baltimore: No. 1531 N. Stricker St. 70 ------- .
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F. White.	W. Female.	Widow.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1 (Year)

7-AGE, 82 yrs. --- mos. --- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Do not know..

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis J. Herr. (son).

(Address) 1531 N. Stricker Street.

15- Robert P. Harrison,

Filed ....., 191.....

MAY 2-1921 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29th, 1921. (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto H. Reinhardt M. D.
(Coroner)

May 1st, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	May 3., 19.21
20-UNDERTAKER	ADDRESS
Martin Faber & Son	827 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

147248. D 53386 — D 53386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital (St.: 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Osmond S. Taylor.

(a) RESIDENCE. No. Emmetsburg, Md. St., Ward. Emmetsburg Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single.

7a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~ Mrs. W. E. Church (sister).

6 DATE OF BIRTH (month, day, and year) April 8, 1898.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wales.

PARENTS

10 NAME OF FATHER Rev. W. S. Taylor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng.

12 MAIDEN NAME OF MOTHER Sara Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eng.

14 Informant (Address) Johns Hopkins Hospital

15 Filed MAY 2 1921 . 19 Robert P. Harrison Record Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1 . 1921 . to May 2 . 1921 . that I last saw him alive on May 2 . 1921 . and that death occurred, on the date stated above, at 9.05 A. m.

The CAUSE OF DEATH* was as follows:

Abscess of liver.
Duration.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Echinococcus Cyst of liver

(duration) yrs. 1 mo mos.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4/4/21

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) A. B. Kidd M. D.

5/2 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmettsburg Md	May 2 1921

20 UNDERTAKER Chas. G. Black ADDRESS 1422 N Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53387

CERTIFICATE OF DEATH.

91 D 53387

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 N Port St ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor Parks

(Residence in Baltimore: No. 1722 N Port St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 6, 1921. (Month) (Day) (Year)

7-AGE, ...yrs. 24 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Raymond H. Parks.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Anna Ennis

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond H Parks

(Address) 1722 N Port St

15-

Filed ..... Robert P. Harrison, Registrar.

MAY 2 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 30, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 24 1921, to April 30 1921, that I saw her alive on April 30 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) ....yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. 1 mos. 1 ds.

(Signed) Albert Eisenberg M. D.

May 2, 1921. (Address) 2027 E North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount DATE OF BURIAL, May 3, 1921.

20-UNDERTAKER Elton V. Tesselaar ADDRESS 2620 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53388

CERTIFICATE OF DEATH.

151 D 53388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5246 Linden Heights Av ST.; 27 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Hawkins

(Residence in Baltimore: No. 5246 Lindenheights St.; ..... yrs., ... mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, 5 (Month) 2 (Day) 1921 (Year)

7-AGE, ... yrs. ..... mos. 4 days. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0.

9-BIRTHPLACE, (State or Country), Balto Maryland.

PARENTS.

10-NAME OF FATHER, Harry Leibowitz

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Kathleen Bennett

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Fred Hawkins

(Address) 5246 Linden Heights Ave

15- Filed MAY 3-1921, 191.. ROBERT J KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 (Month) 2 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1921, to May 2 1921, that I saw h.. alive on May 2 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH was as follows: Premature birth

..... (Duration) ..... yrs. ..... mos. 4 hrs ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robt F Faudel M. D.

5-7-, 191.. (Address) Main & Raynor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	May 3, 1921
20-UNDERTAKER H. M. Gantt	ADDRESS 2237 Raynor Ave.

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-13—H. P. Co.—1000 Bks.

D 53389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53389

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2650 Boone ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Jackson

(a) RESIDENCE. No. 2650 Boone ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): General Housework

(c) Name of employer: Employed at Home

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Phillip Tennant

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Nellie Jackson

(Address) 2650 Boone Ave

15 MAY 3 - 1921 ROBERT [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 29 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 4, 1921, to Apr 29, 1921, that I last saw her alive on Apr 29, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Coral

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Garland Schnull, M. D.

, 19 (Address) 1534 Druid Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Cemetery	5/3/21 19

20 UNDERTAKER: Mrs H A Elliott

ADDRESS 1726 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Tuberculous.
No further history

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53390

CERTIFICATE OF DEATH.

104 D 53390

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 N. Potomac ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris V. Lightner

(a) RESIDENCE. No. 109 N. Potomac ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Walter Lightner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Margaret Etter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Walter Lightner
(Address) 109 N Potomac St.

15 MAY 3 - 1921 ROBERT J. KRAUTH Registrar
Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1921, to May 2, 1921, that I last saw her alive on May 2, 1921, and that death occurred, on the date stated above, at 10.40 a.m.

The CAUSE OF DEATH* was as follows:

acute Ileo-Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. John G. Owens M. D.

May 2, 1921 (Address) 35-a Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	May 5 1921
20 UNDERTAKER	ADDRESS
H. Sander + Sons	1710 Eut St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53391

CERTIFICATE OF DEATH.

79 D 53391

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #304 Laurens Street. ST.: 14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reinhard Julius Wilkens.

(a) RESIDENCE. No. #304 Laurens Street. ST., 14 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 64 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (None-Single)

6 DATE OF BIRTH (month, day, and year) March-6-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired from the

(b) General nature of industry, business, or establishment in which employed (or employer): Tobacco Business.

(c) Name of employer: (self)

9 BIRTHPLACE (city or town) (State or country): Bremen, Germany

PARENTS

10 NAME OF FATHER: Frederick Wilkens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known, Germany

12 MAIDEN NAME OF MOTHER: Augustus Dubel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known, Germany

14 Informant: Mrs. Geo. A. Hax, (niece)
(Address) 508 Woodlawn Road, Roland Pk.

15 Filed MAY 3 - 1921, 19.... ROBERT I. KRAUTER Registrar
Burial Permit Oled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1920, to May 1st, 1921, that I last saw him alive on May 1st, 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Vascular heart disease

duration 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. Chas. Deetjen, M. D.

, 19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May-4-21 19

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 53392

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.:) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Mahoney

(a) RESIDENCE. No. 306 S Chester St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jack Mahoney

6 DATE OF BIRTH (month, day, and year) Dec 17-1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~25~~	23	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleswoman

(b) General nature of industry, business, or establishment in which employed (or employer) Drager Stores

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Martin Lentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Mayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) John Hopkins Hospital, Boards

15 Filed MAY 3 - 1921 Robert J Traynor Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 27 , 1921 , to May 2 , 1921 , that I last saw h[illegible] alive on May 2 , 1921 , and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.
Aortic insufficiency.
Mitral insufficiency & stenosis.
about 11
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) C. H. Mason M. D.

27, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft of Rosary	May 6 1921

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53393

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53393

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1128 Warner St., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Barber Thompson

(Residence in Baltimore: No. 1128 Warner St.; 6 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 1st, 1884
(Month) (Day) (Year)

7-AGE, 36 yrs. — mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Eli Thomas.

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Dora Gardner

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Barber

(Address) 1128 Warner St.

15 MAY 3 - 1921 Filed....., 191... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2nd, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2nd 1921, to May 2nd 1921, that I saw h.. alive on May 2nd 1921, and that death occurred, on the date stated above, 12.45 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)...yrs...mos...ds.

CONTRIBUTORY (Secondary) Pregnancy (Hyperemesis Gravidarum) (Duration) 2 yrs. 9 mos. ds.

(Signed) L. Emmett Morley M. D.

5/2/, 1921 (Address) 908 N. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, May 5, 1921

20-UNDERTAKER J. H. Brown & Son | ADDRESS 1211 Mond St

Be sure that the DISEASE CAUSING DEATH is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53394

CERTIFICATE OF DEATH.

37 D 53394

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 S. Greene ST. 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Barber.

(a) RESIDENCE. No. 216 S. Greene ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Unmarried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Allen Barber

6 DATE OF BIRTH (month, day, and year) Dont 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balls Mill

PARENTS

10 NAME OF FATHER Jeff. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Gertrude Thomas (Address) 216 S Greene

15 MAY 3 - 1921 ROBERT P. BRUTER Burial Permit 0558

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 — 1 — 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-26-, 1921, to 5-1-, 1921, that I last saw h— alive on 5-1-, 1921, and that death occurred, on the date stated above, at 11,11 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Independent.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nil

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. W. Bargill, M. D.

5-2-1921 (Address) 611 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	May 4 1921
20 UNDERTAKER	ADDRESS
S. L. Brown & Son	618 W. Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53395

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53395

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 E Montgomery ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Martin

(a) RESIDENCE. No. 36 E Montgomery ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret M. Martin

6 DATE OF BIRTH (month, day, and year) July 18 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas B. Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel R. Collyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret M. Martin

(Address) 36 E. Montgomery

15 [illegible]

MAY 3 - 1921

[illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 19 20, to May 1, 19 21,

that I last saw he alive on Apr. 30, 19 21,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. Earp Knight, M. D.

5/3 1921 (Address) 910 Eight St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 3, 1921
20 UNDERTAKER	ADDRESS
J. A. Krause & Son	789 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53396

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1616 Druid Hill Ave ST.; 44 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Thos & Anna Lyles

(Residence in Baltimore: No. 1616 Druid Hill Ave St.; ..yrs.. ..mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. 7

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Infant

6-DATE OF BIRTH, May 1, 1921 (Month) (Day) (Year)

7-AGE, ..yrs..mos. 1 ds.

If LESS than 1 day, ..hrs. or 10 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work C
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thos Lyles

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna Douglas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Lyles

(Address) 1616 Druid Hill Ave

15- Filed MAY 3-1921, 191.. ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 1 1921, that I saw her alive on May 1 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Incomplete Physical development: Premature birth. (Duration) ..yrs..mos..ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..yrs..mos..ds.

(Signed) Edw Shorb M. D.

May 2, 191.. (Address) 1612 Druid Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs..mos..ds. In the State ..yrs..mos..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cmty — DATE OF BURIAL, May 3, 1921

20-UNDERTAKER George H Holland — ADDRESS 1637 Druid Hill Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53397

CERTIFICATE OF DEATH.

45 D 53397

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 146 Nelson ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Smith

(a) RESIDENCE. No. 146 Nelson St. Balt. Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, (Widowed) or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Smith

6 DATE OF BIRTH (month, day, and year) May 22-1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John M. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emberson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London

14 Informant Phillip E Smith (Address) 146 Nelson

15 MAY 3-1921 ROBERT E. FRAZER Registrar

Serial No. Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17

I HEREBY CERTIFY, That I attended deceased from April 30, 1921, to May 3, 1921, that I last saw h[illegible] alive on May 1 3, 1921, and that death occurred, on the date stated above, at 12:50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure & Pulmonary oedema (duration) yrs. mos. 5 days

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of May 3, 21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Gray, P. L. M., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	May 6 1921
20 UNDERTAKER	ADDRESS
J Herring & Co	2008 Nelson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53398 ✓D 53398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 Columbia Ave ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma E Thomas

(a) RESIDENCE. NO. 815 Columbia Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 25 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John E Thomas Jr

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Myrtle Z Tuckerman

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant John E Thomas Jr
(Address) 815 Columbia Ave

15 Filed MAY 3 - 1921 19.. ROBERT P. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr. 27, 1921, to May 2, 1921, that I last saw her alive on May 2, 1921, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J M Delevett, M. D.

May 7 1921 (Address) 621 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WESTERN	MAY 3 1921
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Wheeler
2129 N. Smith Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53399 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D 53399

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Clifton St ST. 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Palmisano

(a) RESIDENCE. No. 1813 Clifton St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
27	~~27~~	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Elwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant August Palmisano (Address) 1813 Clifton St

15 Filed MAY 3 - 1921 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to May 1, 1921, that I last saw her alive on April 30, 1921, and that death occurred, on the date stated above, at 13~~0~~ m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Head

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emile Wheeler, M. D.

5/1. 1921 (Address) 2129 Wilmot Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 4th 1921
20 UNDERTAKER Martin Fahey & Sons	ADDRESS 1821 W. Pratt St

BEFORE filling in, read carefully "Suggestions." ALL blanks should be filled EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Master

D 53400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53400

CERTIFICATE OF DEATH.

79

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1136 W. North Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances C. Marlin

(Residence in Baltimore: No. 1136 W. North ave St. (yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, ..., 1852
(Month) (Day) (Year)

7-AGE, 69 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dress Maker
(b) General nature of industry, business, or establishment in which employed (or employer)..... 69

9-BIRTHPLACE, (State or Country), Delaware

PARENTS.

10-NAME OF FATHER, John Brantle

11-BIRTHPLACE OF FATHER (State or Country), Delaware

12-MAIDEN NAME OF MOTHER Sarah Brantle

13-BIRTHPLACE OF MOTHER (State or Country), Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Master Graves

(Address) 1136 W. North ave

15- Filed MAY 3 – 1921 ROBERT E KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Jubular disease of Heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Hostrup M. D.
(Coroner.)

May 2 1921 (Address) 7632 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Locust Lawn N J	May 4, 1921
20-UNDERTAKER	ADDRESS
H E Lesson	814 W 37th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Bowie

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53401

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Bowie

(a) RESIDENCE. No. 140 E Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 23, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Harry Bowie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Luella Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry Bowie (Address) 1468 Mosher St.

15 Filed MAY 3 - 1921 ROBERT P. ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar. 14, 1921, to May 1, 1921, that I last saw h[illegible] alive on May 1, 1921, and that death occurred, on the date stated above, at 10:10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lewis O. Fudgely, M. D.

5/6, 1921 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May. 4 1921
20 UNDERTAKER	ADDRESS
Geo Henry Smith	333 Argyle Ave

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 47895

D 53402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 53402

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 10 WARD)

2-FULL NAME Ray Blumson

(a) RESIDENCE. No. 1207 N Central Ave ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1st 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Isaac Blumson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Sachs.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAY 3 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2nd 1921, to May 2nd 1921, that I last saw h alive on May 2nd 1921, and that death occurred, on the date stated above, at 9.45 p m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

5-3, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehrer Rosedale	5/3 1921
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53403

CERTIFICATE OF DEATH.

8-094 D 53403

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 E. Gough st St.; 3 Ward)

2-FULL NAME Mandy Clough

(a) RESIDENCE. No. 1503 E. Gough St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 17, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John M. Clough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chester Kent Island, Md.

12 MAIDEN NAME OF MOTHER ~~Delaware~~ Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Anna Clough
(Address) 1503 Gough st

15 Filed MAY 3 - 1921 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2nd, 1921, to May 2nd, 1921, that I last saw her alive on May 2nd, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? History & Phys. Examination and Symptoms

(Signed) Harry Linden, M. D.

, 19 (Address) 14 South Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	5-3-1921
20 UNDERTAKER J. J. Moran	ADDRESS 300 E Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53404

CERTIFICATE OF DEATH.

109 D 53404

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Gorsuch & Olivet St. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Weiser

(a) RESIDENCE. No. 1229 N. Eutaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Gertrude H. Weiser

6 DATE OF BIRTH (month, day, and year) aug 2 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Seitz Auto Co

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER George Weiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Eastman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Gertrude Weiser
(Address) 1229 N. Eutaw St.

15 MAY 3 - 1921 ROBERT P. BEAUTLE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1921

17 I HEREBY CERTIFY, That I attended deceased from apr. 4, 1921, to apr 30, 1921, that I last saw him alive on apr. 30, 1921, and that death occurred, on the date stated above, at 4,10 P m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer (Ruptured)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 6 ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? Yes Date of apr. 20, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. M. Elman, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia, Pa	5-4 1921
20 UNDERTAKER J. A. Moran	ADDRESS 300 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53405

CERTIFICATE OF DEATH.

D 53405

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Smallwood ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lowe

(a) RESIDENCE. No. 1604 Smallwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Lowe

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Copperbury (State or country) England

PARENTS

10 NAME OF FATHER do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER do not know

13 BIRTHPLACE OF MOTHER (city or town) Copperbury (State or country) England

14 Informant Mrs Libanus (Address) 1604 Smallwood st

15 Filed ., 19 ROBERT F. [illegible] Registrar

MAY 3 - 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 28, 1921, to May 1, 1921, that I last saw h[illegible] alive on Apr 30, 1921, and that death occurred, on the date stated above, at 5 40 Am. m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J M Libanus, M. D.

5/2, 1921 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	5/4 1921
20 UNDERTAKER Prof Sidney Lows	ADDRESS 1316 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53406

CERTIFICATE OF DEATH.

D 53406

REGISTERED NO. 76

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 Bank ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Joseph Friel.

(a) RESIDENCE. No. 1832 Bank ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel d

6 DATE OF BIRTH (month, day, and year) Jan 25 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John P. Friel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret L. Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John P. Friel
(Address) 1832 Bank St.

15 FILED MAY 3 - 1921 ROBERT P. BRUTON Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 26 1921, to May 1 1921, that I last saw h im alive on May 1, 1921, and that death occurred, on the date stated above, at 1.40 p m.

The CAUSE OF DEATH* was as follows:

Status Medus (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Sinus Thrombosis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A L Tumbleson, M. D.

May 2 1921 (Address) 2013 Bank.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 4th 1921
20 UNDERTAKER Lilly-Zeiler	ADDRESS 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53407

CERTIFICATE OF DEATH.

28 D 53407

1-PLACE OF DEATH US. Public Health Hosp. #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md ST.: 36 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willaim H Smith

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST. Fort McHenry Baltimore Md. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
----

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36 yrs.	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work waiter

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rosenbrock Registrar
(Address) US. PHS Hosp. #56 Ft Henry Md.

15 Filed MAY 3 - 1921 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17

I HEREBY CERTIFY, That I attended deceased from February 23 21, 19..., to May 2 21, 19...,
that I last saw him alive on May 2, 19...,
and that death occurred, on the date stated above, at 11'20 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far adv. (active)

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ----

Was there an autopsy? No

What test confirmed diagnosis? Exam. & Lab. report

(Signed) Thomas B. Reynolds Senior Surgeon (R)

19 (Address) US. PHS Hosp. #56 FT McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philia Pa	May 3. 19 21
20 UNDERTAKER	ADDRESS 1127 E Balto St
J. Frinston & Bro	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53408

CERTIFICATE OF DEATH.

109 D 53408

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospt ST. 2[illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rossmack.

(a) RESIDENCE. No. 12 Lake ave Raspbus. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Rossmack.

6 DATE OF BIRTH (month, day, and year) July 1/1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44 years	10		

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Clerk Western Electric

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John N. Rossmack.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER May Rudesmayer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Rossmack.

(Address) 12 Lake ave Raspbus.

15 Filed MAY 3 - 1921, 19.. ROBERT F. KRAUSE Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1/21 19..

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1921, to May 1, 1921, that I last saw h[illegible] alive on May 1, 1921, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency, (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 26,

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. Schmidt, M. D.

, 19.. (Address) St Joseph's Hosp,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 4 1921,
20 UNDERTAKER Wm. Cook	ADDRESS 502 E North ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operated on for Hernia

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53409

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 53409

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 E Lamont. ST.: Ave 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Windlel

(a) RESIDENCE. NO. 1610 E Lamont. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Fmale	White	Marrie

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Windlel

6 DATE OF BIRTH (month, day, and year) 4/20/1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. ..... min.
	62.	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Andrew Windlel

(Address) 1610 E Lamont Ave.

15 Filed MAY 3 - 1921 19.. ROBERT E KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1920, to May 2, 1921, that I last saw her alive on May 1, 1921, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 6 mos. 21 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At her home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Macdonald, M. D.

May 2, 1921 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 6 1921

20 UNDERTAKER George J. Ruth 1730 Harford Ave.

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53410 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53410

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No. 1338 N. Caroline ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Fletcher Harrigan

(a) RESIDENCE. No. 1338 N. Caroline ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 14 - 1903.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mark J. Harrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Cecelia Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Rev. Eugene Harrigan

(Address) St. Charles College.

15 Filed MAY 3 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd. 19 21

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1921, to May 2nd, 1921, that I last saw him alive on May 2nd, 1921, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Exhaustion, Cardiac

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 0 Date of

Was there an autopsy? 0

What test confirmed diagnosis? Sputum - T. B.

(Signed) J. T. Rhoads, M. D.

, 19 (Address) 900 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery.	5/ 4/21. 19

20 UNDERTAKER Chas F. Evans & Son ADDRESS 1187 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Ditto marks should not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53411

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 53411

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 Elm ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Josephine Corbett

(Residence in Baltimore: No. 1920 Elm St.: 7 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~. (*Write* the word.)

6-DATE OF BIRTH, March 2, 1901 (Month) (Day) (Year)

7-AGE, 20 yrs. 2 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cash factory worker
(b) General nature of industry, business, or establishment in which employed (or employer): Store Cashier

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Michael Corbett

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Delia McHale

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF ~~MY~~ KNOWLEDGE.

(Informant) Lawrence M Corbett

(Address) 726 Parma Ave

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.
~~Burial Permit Clerk.~~

MAY 3 - 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1921, to May 2 1921, that I saw h[illegible] alive on May 1 1921, and that death occurred, on the date stated above, at 7 45 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) [illegible] yrs. ..... mos. ..... ds.

(Signed) Edwin K. Ballard M. D.

May 2, 1921 (Address) 1622 Mt Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Holy Cross Cem.	5 6, 1921
20-UNDERTAKER	ADDRESS
Chas. H. Cross & Son	1624 Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D 53412

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3334 Beach Ave WARD 13)

2-FULL NAME Charles L Alban

(a) RESIDENCE. NO. 3334 Beach Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Singell

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	✓	✓	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James C Alban

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Clara M Small

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) James C Alban 3334 Beach Ave

15 Filed MAY 3 - 1921 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 3, 1921, that I last saw him alive on May 2, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(about 6 months)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no disease

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

May 3, 1921 (Address) 846 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	May 3 1921

20 UNDERTAKER Chenowith Son ADDRESS Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 3 - 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53413 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53413

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 S. Ann ST.; 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Novak

(a) RESIDENCE. NO. 813 S Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 17, 20

7 AGE Years 1 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William Novak

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mary Zabrotska

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Joseph Novak
(Address) 813 S Ann

15 Filed MAY 3-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1921, to May 3, 1921, that I last saw h[illegible] alive on May 2, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. | DATE OF BURIAL May 4" 1921

20 UNDERTAKER M F. Sadowski | ADDRESS 905 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53414

HEALTH DEPARTMENT—CITY OF BALTIMORE

120

D 53414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2570 W. Fayette (St.) 20 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Butler Cunningham

(a) RESIDENCE. (Usual place of abode) No. 2570 W. Fayette St., Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Cunningham

6 DATE OF BIRTH (month, day, and year) May 14/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Geo. A. Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Rose Fischer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Elizabeth M. Cunningham (Address) 2570 W. Fayette St

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1921, to May 1, 1921, that I last saw him alive on May 1, 1921, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease

(duration) Unknown yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ....Date of ....

Was there an autopsy?

What test confirmed diagnosis?

5/3, 1921 (Signed) W. H. O'Neill, M. D. (Address) 108 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 4 2 1921
20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2303 E. Monument ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53415

CERTIFICATE OF DEATH.

47 D 53415

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2678 Penna. Ave ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecelia Ella Rittenhouse

(Residence in Baltimore: No. 2678 Penna. Ave. St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, Feb 2nd (Month) (Day), 1885 (Year)

7-AGE, 36 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James F. Jones

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Rebecca Snelling

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J. Rittenhouse

(Address) 2678 Penna Ave

15-

Filed ..... 1921 Robert P. Harrison, Registrar.

MAY 3 - 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20 1918, to May 1 1921, that I saw h ee alive on April 30 1921, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Arthur C. Harris M. D.

5/2, 1921. (Address) 76 00 E Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Hill Cemetery DATE OF BURIAL, May 4 1921

20-UNDERTAKER Putnam Bros & C 1723 N Gay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D 53416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 53416

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1116 Pennington Ave ST. Curtis Bay 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Martinionis.

(Residence in Baltimore: No. 1116 Pennington Ave. Curtis Bay. 14 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1 (Year)

7-AGE, 39 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Car repairer. 13
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.

9-BIRTHPLACE. (State or Country), Lithuania.

PARENTS.

10-NAME OF FATHER, George Martinionis.

11-BIRTHPLACE OF FATHER (State or Country), Lithuania.

12-MAIDEN NAME OF MOTHER Adelia, ----------

13-BIRTHPLACE OF MOTHER (State or Country), Lithuania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Bajoros.

(Address) 1509 Pennington Ave. Curtis Bay.

15- Robert P. Harrison, Filed ..., 191.. Burial Permit Clerk.
MY 3 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2nd. 1921. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

May 3rd., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross	May 4, 1921

20-UNDERTAKER	ADDRESS
John Gobliauckas	425 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D 53417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175-001 D 53417

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Fredrick Rd & North Ave. WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. J. Mc. Cracken.

(Residence in Baltimore: No. 838 E Preston St.: yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (*Write* the word.): Married

6-DATE OF BIRTH: ..... Jan 1- ....., 1856
(Month) (Day) (Year)

7-AGE: 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Broker.
(b) General nature of industry, business, or establishment in which employed (or employer): do.

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER: James McCracken

11-BIRTHPLACE OF FATHER (State or Country): Ireland.

12-MAIDEN NAME OF MOTHER: Katherine Haugney

13-BIRTHPLACE OF MOTHER (State or Country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. J. McCracken

(Address) 838 E. Preston

15-

Robert P. Harrison,

Filed ....., 191.....

MAY 3 - 1921 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: ..... May- 1- ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. Auto-Accident

(Duration) ..... yrs. ..... mos. 1 hr.

CONTRIBUTORY (Secondary) Shock.

(Duration) ..... yrs. ..... mos. ..... hrs.

(Signed) Geo Clinton Black M. D.
(Coroner)

5/1/21 (Address) 1436 Bway.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, May 4, 1921

20-UNDERTAKER Margaret J. Flynn ADDRESS 1452 Light St.

* Entry item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Gasoline tank ignited, was fixing
pt machine

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53418

HEALTH DEPARTMENT—CITY OF BALTIMORE

15 D 53418

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Infant of George & Mary Schmidt

CITY OF BALTIMORE: (No. 601 N. Kennard St.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Not named

(a) RESIDENCE. No. 601 N Kennard St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/1/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. min.
		5 mos	4 hrs	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary C Hemmeter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mr Schmidt 601 N Kennard St

15 Filed MAY 3-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1/21

17 I HEREBY CERTIFY, That I attended deceased from 5/1/21, 19..., to 5/1/21, 19..., that I last saw h... alive on 5/1/21, 19..., and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Premature (5 mos in utero)

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) Uterine Prolapse

(duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. L. Meyer M. D.

(Address) N. 32 St & Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAY 3 1921

20 UNDERTAKER

ADDRESS

Commissioner of Health.

For Wm. F. WOODAL...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53419

CERTIFICATE OF DEATH.

81 D 53419

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 W.Fayette St. ST.: 19 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M.Costello.

(a) RESIDENCE. No. 1719 W.Fayette St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Costello

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Killulky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Agnes Feehley.

(Address) 1719 W.Fayette St.

15 Filed MAY 3-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to May 2, 1921, that I last saw h.r alive on April 30, 1921, and that death occurred, on the date stated above, at ——— m.

The CAUSE OF DEATH* was as follows:

Uterine Sclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) Edw. V. Coolahan M. D.

, 19 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cemetery	May 4 1921
20 UNDERTAKER	ADDRESS
John A Moran	3000 E. Balto.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No haemorrhage

D 53420

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

42

D 53420

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE (No. 400 S. 12 ST.: [illegible] WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Prkena

(Residence in Baltimore: No. 400 S 12 St.: 35 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): M Married

6 DATE OF BIRTH: Sept. (Month) 4 (Day), 1864 (Year)

7 AGE: 56 yrs. 7 mos. 30 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of indu try, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Austria

PARENTS

10 NAME OF FATHER: [illegible] Zahora

11 BIRTHPLACE OF FATHER (State or country): Austria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Austria

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Prkena

(Address) 400 S. 12th St

15. Filed ..... 191.....

Robert P. Harrison,
Burial Permit Clerk. REGISTRAR

AY 3 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 3 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1921 to May 3 1921, that I saw h[illegible] alive on May 3 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Carcinoma

(Duration) 2 1/2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Intestinal metastasis Carcinoma

(Duration) ..... yrs. 1 mos. 7 ds.

(Signed) J. A. Hearn M. D.

May 4, 1921 (Address) 3244 Eastern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 5 yrs. ..... mos. ..... ds. In the State 35 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Dal Lawn — DATE OF BURIAL: May 6, 1921

20 UNDERTAKER: John A. Moran — ADDRESS: 3000 E. Baltimore St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53421

HEALTH DEPARTMENT—CITY OF BALTIMORE

175-001 D 53421

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar C. Shiletto

(Residence in Baltimore: No. 1036 Brentwood St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Don't Know (Month) (Day) 1 (Year)

7-AGE, 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Policeman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, Griffith Shiletto

11-BIRTHPLACE OF FATHER (State or Country), Penna'

12-MAIDEN NAME OF MOTHER Don't Know'

13-BIRTHPLACE OF MOTHER (State or Country), Penn'

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. E. Domes

(Address) Odenton Md

15-

Filed MAY 3 1921, 191

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fractured Skull & internal Injuries
(Duration) a few hours

CONTRIBUTORY (Secondary) in collision with automobile
(Duration) yrs. 7 mos. ds.

(Signed) W. J. Gorsuch M. D.
(Coroner.)
5-3, 1921 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, U. S. National Cem. DATE OF BURIAL, May 4 1921

20-UNDERTAKER Wm Cook ADDRESS 502 E Mart

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53422

CERTIFICATE OF DEATH.

184 D 53422

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Providence Hosp. St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Olivia Hammond

(Residence in Baltimore: No. 1701 W. Franklin St. 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female. 4-COLOR OR RACE, colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, November, 1898
(Month) (Day) (Year)

7-AGE, 22 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Nathaniel Henson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Maggie Henson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Hammond,

(Address) 1701 W. Franklin St.

15- Filed MAY 4 - 1921 191... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute peritonitis due to criminal abortion (Puerperal septicemia)

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Abortion performed 2 wks previous,

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

May 3, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Providence Hosp. In the of death yrs. mos. 2 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1701 W. Franklin St.

Former or usual residence Same.

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery DATE OF BURIAL, May 6 1921

20-UNDERTAKER Samuel J. Hensley ADDRESS 678 N. Bridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53423

CERTIFICATE OF DEATH.

28 D 53423

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Argyle ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Ford

(a) RESIDENCE. No. 1216 Argyle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Ford

6 DATE OF BIRTH (month, day, and year) Nov. 4. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer New Howard Hotel

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER John Edward Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Mary Emily Dodson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlestown Md

14 Informant William J Ford

(Address) 1216 Argyle Ave

15 MAY 4 - 1921 ROBERT P. KRAUSE Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1921, to May 1, 1921, that I last saw h. alive on May 1, 1921, and that death occurred, on the date stated above, at 11.55 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Sputum.

(Signed) Wm H Wright, M. D.

May 2 1921 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cem	May 4 1921
20 UNDERTAKER	ADDRESS
Samuel J Hemsley	578 W Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53424

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53424

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 Wilkins Ave ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Sheehan

(a) RESIDENCE. No. 1921 Wilkins Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno Sheehan

6 DATE OF BIRTH (month, day, and year) March 26-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Cuskey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant E. F. Koff

(Address) 1921 Wilkins Ave

MAY 4 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1921, to May 2, 1921, that I last saw h alive on May 2, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exp.

(Signed) J. Norwood, M. D.

May 2 1921 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 5 1921
20 UNDERTAKER	ADDRESS
John Howard Lee	901 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53425

CERTIFICATE OF DEATH.

REGISTERED NO. 2779

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Chestnut Hill Ext Waverly WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert H. Weber

(a) RESIDENCE. No. Chestnut Hill Mt Washington WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ anna weber

6 DATE OF BIRTH (month, day, and year) 1. 16. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	45	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER August weber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Helene Hobelmann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Anna Weber
(Address) Mt Washington Md

15 MAY 4 - 1921 [illegible] Registrar
Burial Permit Dist

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 3. 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1920, to May 3, 1921, that I last saw him alive on May 3, 1921, and that death occurred, on the date stated above, at 3.06 A. m.

The CAUSE OF DEATH* was as follows:

Initial Regurgitation with Hypertrophy

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Time heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) C. H. Beeler M. D.

5. 3, 1921 (Address) Mt Washington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	5/4 1921
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53426

CERTIFICATE OF DEATH.

28 D 53426

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Alurdas

(a) RESIDENCE. No. 1712 Thames st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dish-washer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Christian Alurdas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Records
(Address) M.T.H.

15 Filed MAY 4 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1921, to May 3, 1921, that I last saw him alive on May 2, 1921, and that death occurred, on the date stated above, at 4.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. Digney, M. D.

5-5-21. (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	May 6 1921
20 UNDERTAKER	ADDRESS
J. Henry & Co	1008 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53427 ✓ D 53427

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 E 30th St.; 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Lohmeyer

(a) RESIDENCE. No. 902 E 30th St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 3/1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Chas Lohmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Caroline Mohr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Annie Mohr (Address) 902 E 30th

15 Filed MAY 4 - 1921 ROBERT J KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from May 3rd, 1921, to May 3, 1921, that I last saw her alive on 3rd May 1921, and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Pressure on umbical cord during Podalic version & extraction - following face presentation - (duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dr. Butler C. Lapeman, M. D.

May 3 1921 (Address) 2703 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Park Wood Cem — DATE OF BURIAL: May 4 1921

20 UNDERTAKER: J Henrig & Co — ADDRESS: 2008 Allen

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Mrodreszeska

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53428 ✓ D 53428

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 Hudson ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Mrodreszeska

(a) RESIDENCE. NO. 1824 Hudson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/4/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.
		5 mo		

after gestation

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Joseph Mrodreszeska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Mulosey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Joseph Mrodreszeska 1824 Hudson St

15 Filed MAY 4 — 1921 EMERY F. TRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4 1921

17 I HEREBY CERTIFY, That I attended deceased from on 5/4 1921, to ....., 19....., that I last saw her alive on 5/4/21, 19....., and that death occurred, on the date stated above, at 7:10 m.

The CAUSE OF DEATH* was as follows:

Premature birth
5 mos. utero gestation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Karlinsky M. D.

5/4, 1921 (Address) 3035 E Dorsett St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	May 5 1921
20 UNDERTAKER	ADDRESS
Jacob Fiedkowski	425 S. Bond

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53429

CERTIFICATE OF DEATH.

64 D 53429

1-PLACE OF DEATH 1522 N. Bond St

CITY OF BALTIMORE: (No. 1522 N Bond ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mary Muldoon

(a) RESIDENCE. NO. 1522 N. Bond ST., WARD. 8

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E Muldoon

6 DATE OF BIRTH (month, day, and year) Jan 27 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER — Theile

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Prussia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Prussia (State or country)

14 Informant Son Wm J Muldoon (Address) 1522 N Bond St

15 Filed MAY 4-1921 ROBERT P. ... Registrar

Record Death Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 1921, to May 2 1921, that I last saw her alive on May 2 1921, and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death? Her home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A E Mustard, M. D.

May 2, 1921 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	May 5 1921
20 UNDERTAKER	ADDRESS
Chas E Franck	502 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Klavan

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53430

D 53430

CERTIFICATE OF DEATH.

1921

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1654 Bentalou ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Klavan

(a) RESIDENCE. No. 1654 Bentalou ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 7, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Solomon Klavan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Kanter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

11 Informant Solomon Klavan
(Address) 1654 N. Bentalou

15 FILED MAY 4 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/29, 1921, to 5/3, 1921, that I last saw him alive on 5/3, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Malnutrition

(duration) yrs. 6 mos. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Lewis A. Ridgely M. D.

5/3, 1921 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Southern Cem.,	May 4 1921

20 UNDERTAKER Jack Lewis, ADDRESS 1411 E. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53431

CERTIFICATE OF DEATH.

89 D 53431

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 S. Exeter ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Becker

(a) RESIDENCE. No. 112 S. Exeter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4 - 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Becker

(Address) 112 S Exeter St

15 FILED MAY 4 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1921, to ..., 19..., that I last saw him alive on Apr 30, 1921, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions 1 day, Microcephaly, since birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) A. Reis, M. D.

May 5, 1921 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sherwood Memorial Park	5/4 1921
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state plainly what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 53432

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1402 E. Chase ST.: 10, WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jones

(a) RESIDENCE. No. 1402 E. Chase ST., 10, WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. — mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 14-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizab. Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary F. Ogden
(Address) 1402 E. Chase st

15 Filed MAY 4 - 1921 ROBERT J. [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1920, to May 2, 1921, that I last saw him alive on May 2, 1921, and that death occurred, on the date stated above, at 9 10 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia of Left side
due to Hemorrhage

(duration) or yrs. 9 mos. 21 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby M. D.

5/3/1921 (Address) 1223 N. Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Bur. Hanford ave	May 5 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mrs. D. Baker

D 53433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53433

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3442 Auchentorly Terrace ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Baker

(a) RESIDENCE. No. 3442 Auchentorly Terrace ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Baker

6 DATE OF BIRTH (month, day, and year) Dec 10, 1857

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co, Md

PARENTS

10 NAME OF FATHER Samuel Bratt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maryann Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Daniel Baker

(Address) 3442 Auchentorly Terrace

15 Filed MAY 4 - 1921 ROBERT [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1921.

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1921, to May 2, 1921, that I last saw her alive on May 2, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Bladder.

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Acute Nephritis + Pyelitis,

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) A. F. Robinson M. D.

5/2, 1921 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 4 1921
20 UNDERTAKER John A. Mitchell	ADDRESS 1201 W Fayette

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should write plainly and carefully supplied. AGE

D 53434

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 40

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Rutland ave ST.; 8 WARD)

2-FULL NAME Mary E Bentz

(a) RESIDENCE. No. 12th & Gerard ave S. Brookland Washington DC WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md (State or country)

PARENTS

10 NAME OF FATHER Henry Bentz

11 BIRTHPLACE OF FATHER (city or town) Lancaster Pa (State or country)

12 MAIDEN NAME OF MOTHER Catherine DeGrange

13 BIRTHPLACE OF MOTHER (city or town) France (State or country)

14 Informant Clara J Keil (Address) 1616 Rutland ave

15 Filed MAY 4 - 1921 19 ROBERT J KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 2 1921

17 I HEREBY CERTIFY, That I attended deceased from APR 30 1921 19..... to MAY - 2 - 1921 19.....

that I last saw him alive on MAY - 2 - 1921 19.....

and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma due carcinomata Brain testis and liver

(duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma Prostate

(duration) 2 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? Wash DC

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) O H Duker M. D.

MAY 3 1921 19 (Address) 928 F North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md	May 5th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53435

CERTIFICATE OF DEATH.

151

D 53435

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 E Chase St.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. Schmidt

(Residence in Baltimore: No. 1738 E Chase St.; — yrs. — mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, April (Month) 27 (Day), 1921 (Year)

7-AGE, — yrs. — mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Geo. E Schmidt

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER May Abel

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Geo C. Schmidt

(Address) 1738 E. Chase St.

15- MAY 4 - 1921 Filed....., 191.... ROBERT J KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 3 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 3 1921, that I saw him alive on May 2 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cranium due to Premature birth

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary).....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jacob Friedman M. D.

May 3, 1921 (Address) 1823 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem

DATE OF BURIAL, May 4th, 1921.

20-UNDERTAKER Peter Nicolaus

ADDRESS 6046 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53436

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 53436

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 16 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Thorn

(a) RESIDENCE. No. 803 N. Bruce st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Amanda Thorn

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Thorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address) M.T.H.

15 MAY 4 - 1921 Burial Permit Issued [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from January 18, 1921, to April 29, 1921, that I last saw him alive on April 28, 1921, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis and peritonitis (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) J. Gray, M. D.

4-29-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
J. H. Fulgum	5/4/21
20 UNDERTAKER Sam'l N. Chase & Son	ADDRESS 1400 Monument

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should be certainly supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53437

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Riverside Ave ST. 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Lawton Sr.

(a) RESIDENCE. No. 1113 Riverside Ave ST. 24th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 7 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Margaret Jane Lawton

6 DATE OF BIRTH (month, day, and year) September 10, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	81	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith, Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Penaylvania Rail Road

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Lawton

11 BIRTHPLACE OF FATHER (city or town) Town unknown (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Eliz. Brazer

13 BIRTHPLACE OF MOTHER (city or town) Hartford Co., (State or country) Maryland.

14 Informant Wife. Margaret Jane Lawton

(Address) 1113 Riverside Ave, Balto. Md.

15 MAY 4 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to May 1, 1921, that I last saw him alive on May 1, 1921, and that death occurred, on the date stated above, at 8 00 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 15 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

5/1/1921 (Address) 1049 Riverside Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible] Cemetery	May 4 1921

20 UNDERTAKER E J Benning ADDRESS 460 Duttery ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53438

CERTIFICATE OF DEATH.

170 D 53438

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 231 E. North Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Alexander Robinson

(a) RESIDENCE. No. 231 E North Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 25 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Wm Wallace Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annabelle Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Alice M Best

(Address) 231 E. North Ave

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920, to May 3, 1921, that I last saw h[illegible] live on May 3, 1921, and that death occurred, on the date stated above, at 5.45 p.m.

The CAUSE OF DEATH* was as follows:

[illegible]

(duration) yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

May 4, 1921 (Address) Comfort Sta. & Res. Comfort

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakville-Ontario	May 4 1921
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	North & Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53439

CERTIFICATE OF DEATH.

92 D 53439

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 Penna Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Barber

(a) RESIDENCE. No. 122 Pa Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mine

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Barber

11 BIRTHPLACE OF FATHER (city or town) Ft Morris Va
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Powell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Emma Barber
(Address) 122 penna ave.

15 Filed MAY 4 - 1921 ROBERT J. KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 19.., to May 2nd, 1921, that I last saw h.. alive on May 2nd, 1921, and that death occurred, on the date stated above, at 10-30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Purnell Tapp, M. D.

, 19 (Address) 714 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 4 1921

20 UNDERTAKER Samuel Hensley & Bible ADDRESS 178

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other infection

Spec.—8-24-14—M. & T.—2000 Bks.

Mc Quade ✓

D 53440 HEALTH DEPARTMENT—CITY OF BALTIMORE

+64 D 53440

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 McCollough ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony McQuade

(Residence in Baltimore: No. 1104 McCollough St.; yrs., mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 2nd, 1866
(Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Kent Co Md

PARENTS.

10-NAME OF FATHER, Anthony McQuade

11-BIRTHPLACE OF FATHER (State or Country), Kent Co Md

12-MAIDEN NAME OF MOTHER Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country), Kent Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie N. Clayton

(Address) 1104 Mc Culloh St

MAY 4 - 1921 ROBERT I KRAUTER

Filed....., 191.... Burial Permit Issued

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2nd, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 25th 1921, to May 2nd 1921, that I saw h alive on May 1st 1921, and that death occurred, on the date stated above, at 4.05 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

May 4th, 1921 (Address) 607 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Charlestown Md

19-PLACE OF BURIAL OR REMOVAL, Charlestown Md

DATE OF BURIAL, May 5, 1921

20-UNDERTAKER John H Owens

ADDRESS 1-38 Dolphin St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53441

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53441

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3407 Bank Street ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella M. Potts

(a) RESIDENCE. No. Oak Drive, Windsor Terrace ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob C. Potts

6 DATE OF BIRTH (month, day, and year) July 23rd 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Johnstown, Pennsylvania

PARENTS

10 NAME OF FATHER Samuel Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Eliza Edmondson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Jacob C. Potts

(Address) Oak Drive, Windsor Terrace

15 Filed MAY 4-1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 19 21

17 I HEREBY CERTIFY, That I attended deceased from Apr 24, 1921, to May 2, 1921, that I last saw her alive on May 2, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Mitral Insufficiency.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Woodruff, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	May 5 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29

D 53442

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1008 n. Wolf. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Thompson

(Residence in Baltimore: No. 1008 n. Wolf. St.; (yrs., 6) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) (Day) 1903 (Year)

7-AGE, 18 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer Worker
(b) General nature of industry, business, or establishment in which employed (or employer): 670

9-BIRTHPLACE, (State or Country) Eastern Shore Md

PARENTS.

10-NAME OF FATHER, Samuel Thompson

11-BIRTHPLACE OF FATHER (State or Country), Ind

12-MAIDEN NAME OF MOTHER Ella Pritchett

13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Pritchett

(Address) Taylor Island Md

15- Filed ....., 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

MAY 4 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Hadley M. D.
(Coroner)
May 5, 1921 (Address) 4 E. Eutaw st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Taylors Island Md

DATE OF BURIAL, May 5, 1921

20-UNDERTAKER Chas L Hadley

ADDRESS 1421 Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Body at city morgue

D 53443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53443

CERTIFICATE OF DEATH.

79

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 854 Vine St.: 18 WARD) REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Martin E. Holmes

(Residence in Baltimore: No. 854 Vine St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Don't Know (Month) 1 (Day) (Year)

7-AGE, 37 about yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Dont Know

PARENTS.

10-NAME OF FATHER, —

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed Robert B. Harrison, Registrar.

MAY 4 - 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 24 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (~~Inquest, autopsy,~~ or inquiry.) thereon and from the evidence obtained by said (~~Jurors, on autopsy or inquiry.~~) find that said deceased came to ~~h~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

April 30, 1921 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, MAY 4 - 1921

20-UNDERTAKER Commissioner Health. ADDRESS

Rev. Wm. E. WOODALL

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53444 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53444

91

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 201 W. Hoffman St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice G. Gay

(Residence in Baltimore: No. 201 W. Hoffman St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec. 23, 1920.
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Infant)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Cornelius Gay

11-BIRTHPLACE OF FATHER (State or Country), N. Carolina

12-MAIDEN NAME OF MOTHER Jamie Harris

13-BIRTHPLACE OF MOTHER (State or Country), N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jamie Gay

(Address) 201 W. Hoffman St.

15- Robert P. Harrison,
Filed....., 19..... Registrar.

MAY 4 - 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration)..... yrs..... mos. 14 ds.

CONTRIBUTORY (Secondary) no history

(Duration)..... yrs..... mos..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

May 3, 1921 (Address) 2802 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL. DATE OF BURIAL, ..., 19....

20-UNDERTAKER Commissioner Health ADDRESS MAY 4 - 1921

Rec. Wm. R. WOGDALE

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53445

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1517 Division ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Flora Simpson

(a) RESIDENCE. No. Marlborough Apts ST.: — WARD.

(Usual place of abode)

Length of residence in city or town where death occurred All her life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Solomon Simpson

6 DATE OF BIRTH (month, day, and year) Oct 19-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Moses Kemper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Fanny Jump

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria —

14 Informant Hosp Record.

(Address)

15 Filed Robert P. Harrison, Registrar

MAY 4-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 8, 1921, to May 3, 1921, that I last saw her alive on May 3, 1921, and that death occurred, on the date stated above, at 9.40 A. m.

The CAUSE OF DEATH* was as follows:

Hydronephrosis —
Nephrectomy (4-18-21)
Iodoform Poisoning
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism
(duration) Hrs. yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes. Date of 4/18/21

Was there an autopsy? No

What test confirmed diagnosis? Operation. X Ray

(Signed) J. A. Blackerby M. D.

5/3. 1921 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	5/5 1921
20 UNDERTAKER	ADDRESS
Hart & Sondheim	1118 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53446

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3031 Belmont Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archibald Shadrick

(a) RESIDENCE. No. 3031 Belmont Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? 31 yrs. 3 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Helen Shadrick

6 DATE OF BIRTH (month, day, and year) Jan. 19 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cartoonists

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Archibald F. Shadrick

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Francis A. Kane

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs. Willett
(Address) 3031 Belmont

15 Filed Robert P. Harrison, Registrar
MAY 4-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1921, to May 3, 1921, that I last saw him alive on May 2, 1921, and that death occurred, on the date stated above, at 10.50 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Lundquist M. D.

May 5 1921 (Address) 826 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	5/5 1921
20 UNDERTAKER	ADDRESS
J. Frew McCarthy	130 E. Fay

MAR[illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53447

HEALTH DEPARTMENT—CITY OF BALTIMORE

120

D 53447

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Gibson

(a) RESIDENCE. No. 63 E. Monroe. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 15-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~25~~ 26	..	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator 086

(b) General nature of industry, business, or establishment in which employed (or employer) Shirt Factory

(c) Name of employer Kinder Factory

9 BIRTHPLACE (city or town) (State or country) Cato Md

PARENTS

10 NAME OF FATHER John Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredk. Co. Md.

12 MAIDEN NAME OF MOTHER Mary Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mary Gibson
(Address) 63 E. Monroe

15 Filed AY 4 - 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-24, 1921, to 5-2, 1921, that I last saw h[illegible] alive on 5-2 1921, and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis (duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. M. Craig (Res. W) , M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 5 1921.
20 UNDERTAKER	ADDRESS
S. A. Offutt, Jr.	228 E. Fayette St.

NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53448

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 109 N. Clare St. Alley 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Pfleger

(a) RESIDENCE. NO. 109 N. Clare St. WARD. Alley

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced: HUSBAND of (or) WIFE of John Pfleger

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
About	40.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Jersey Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: John Pfleger

(Address) 109 N. Clare St. City

15 MAY 4 1921, 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/4/1921

17 I HEREBY CERTIFY, That I attended deceased from 5/2/21, to 5/4/21,

that I last saw h.. alive on 5/4/21,

and that death occurred, on the date stated above, at 1145 A.M. m.

The CAUSE OF DEATH* was as follows:

Chr. Diff. Nephritis

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical symptoms

(Signed) Leonard J. Levy, M. D.

5/4, 19 21 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	5/6/21
20 UNDERTAKER: William Cook	ADDRESS: 604 E. N Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53449

CERTIFICATE OF DEATH.

152

D 53449

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 15 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hoffman

(Residence in Baltimore: No. 2310 Fiaga Place St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	

6-DATE OF BIRTH, May 4 Or, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ½ hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Israel Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rebecca Blum

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E. Baltimore St.

15- MAY 5 1921 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 4, 1921, that I saw h-r alive on May 4, 1921, and that death occurred, on the date stated above, at 1:15 p.m.

The CAUSE OF DEATH* was as follows:

Nausea in air passages

..... (Duration) ..... yrs. ..... mos. 1½ hrs.

CONTRIBUTORY (Secondary) Asphyxia Livida

..... (Duration) ..... yrs. ..... mos. 1½ hrs.

(Signed) C. R. Kaganty M. D.

May 4, 1921. (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1½ hrs. In the State ..... yrs. ..... mos. 1½ hrs.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Herring Run	May 5, 1921.
20-UNDERTAKER	**ADDRESS**
Jack Lewis	1411 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53450

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 E Pratt St. ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abe Kimin

(a) RESIDENCE. No. 1921 E Pratt St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Kimin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 27; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Kimin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bekie Eli

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E Balto St

15 [illegible] 19 [illegible] Registrar

MAY 5 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17 I HEREBY CERTIFY, That I attended deceased from October — , 1920 , to May 4 , 1921 , that I last saw h[illegible] alive on May 4 , 1921 , and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Tb. in sputum

(Signed) Jack Cohen, M. D.

May 5 1921 (Address) 223 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen Circle Mt. Carmel — DATE OF BURIAL: May 5 1921

20 UNDERTAKER: Jack Lewis, ADDRESS 1411 E. Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Louisa Herd

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53451

CERTIFICATE OF DEATH.

43 D 53451

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 Emory St.: 22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Herd

(a) RESIDENCE. No. 218 Emory St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Fredrick Herd

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Co Md

PARENTS

10 NAME OF FATHER Rudolph Bleiler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara ...

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred Herd
(Address) 218 Emory St

15 Filed MAY 5 - 1921 19 ROBERT J. KRAUTH Registrar
Serial No. 11 Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from July 3 1920, to May 3 1921, that I last saw h.r alive on May 2 1921, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) ... yrs. 10 mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Fanny Boyd, M. D.

(Address) 622 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 5th 1921
20 UNDERTAKER	ADDRESS
Geo Leimbach & Son	647 W. Balto

N. B.—WHITE PAPER, neatly supplied. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KATE JOHNSON ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53452

CERTIFICATE OF DEATH.

50

D 53452

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 421 N Bethel St, St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Johnson

(Residence in Baltimore: No. 421 N Bethel St.; (yrs. 38 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, Unknown ....., 1871
(Month) (Day) (Year)

7-AGE, 30 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), St Mary Co Md.

PARENTS.

10-NAME OF FATHER, Anthony Lee

11-BIRTHPLACE OF FATHER (State or Country), St Mary Co,

12-MAIDEN NAME OF MOTHER Sallie —

13-BIRTHPLACE OF MOTHER (State or Country), Saint Mary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Hughes

(Address) 421 N. Bethel St

15- Filed MAY 5 - 1921, 191.....

ROBERT I. KRAUTER
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lebary Cem, DATE OF BURIAL, May 6th, 1921.

20-UNDERTAKER Harvey A Vodery ADDRESS 1726 Orleans St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53453

CERTIFICATE OF DEATH.

135 D 53453

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST. 96 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jennie Knobb

(a) RESIDENCE. NO. 438. S 12th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Knobb

6 DATE OF BIRTH (month, day, and year): May 27-1892

7 AGE — Years: 29 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Seybold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Fiestman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Henry Knobb (Address) 432 E. 12th St.

15 Filed MAY 5 - 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/3/ 1921

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1921, to May 3, 1921, that I last saw h alive on May 2, 1921, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pleurisy Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/2/21

Was there an autopsy? No

What test confirmed diagnosis? P.M. & Symptoms

(Signed) Frank C Mussina, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem.

DATE OF BURIAL: May 1921

20 UNDERTAKER: Lilly and Zeiler

ADDRESS: 403 N. Howard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53454

CERTIFICATE OF DEATH.

D 53454

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 17 WARD) REGISTERED NO. C 172

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar Leigear

(Residence in Baltimore: No. Idaps ov Ave St. Arlene 401 Winchester ave St.; yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Divorced

6-DATE OF BIRTH, ... (Month), 1 (Day), ... (Year)

7-AGE, 39 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gardener
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William Leigear

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Eliz Johnson

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Hattie Babylon

(Address) 401 Winchester Ave.

15-

Filed MAY 5 - 1921 ROBERT J. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. of Femur Shock

Accidentally fell with bed

after he had partly burned off

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D. (Coroner.)

May 3, 1921. (Address) 1657 Bus

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence Catasauqua Pa

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Dry Hill Cem Laurel Md	May 5, 1921
20-UNDERTAKER	**ADDRESS**
Lilly & Zuler	403 S. Wolfe St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53455

CERTIFICATE OF DEATH.

53 D 53455

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur L. Pickett

(Residence in Baltimore: No. Riverview Terrace, Colgate, Md. St.; ..... yrs., 1 mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... April (Month) 12 (Day), 1863 (Year)

7-AGE, 58 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robert E. Pickett

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Hannah A Cecil.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Ida V. Pickett

(Address) Riverview Terrace Colgate Md.

15- MAY 5 - 1921

Filed....., 191... [illegible] Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) 3rd. (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 13th. 1921, to May 3rd. 1921, that I saw him alive on May 3rd. 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as followa:

Chronic Lymphatic Leukemia

..... (Duration) 1 yrs. 1 mos. ..... ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... J. A. Zinberg ..... M. D.

May 3rd., 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Colgate Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem.	May 6..., 1921.

20-UNDERTAKER	ADDRESS
Lilly & V Zinberg	403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53456

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2703 Eastern Ave ST.: 1 WARD)

2-FULL NAME Mary Helen Zinkand

(a) RESIDENCE. NO. 2703 Eastern Ave ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Five yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Zinkand

6 DATE OF BIRTH (month, day, and year) Jan. 16-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wolfgang Bittrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Margaret Mindel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant William J. Zinkand

(Address) 2703 Eastern Ave.

15 FILED MAY 5-1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 25 1921 to May 3 1921, that I last saw her alive on May 1 1921, and that death occurred, on the date stated above, at 12.35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Tubul Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ins

(Signed) C L Lay, M. D.

May 4 1921 (Address) 2701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	May 6 1921
20 UNDERTAKER	ADDRESS
Lilly & Zihn	403 S Wolfe.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53457

CERTIFICATE OF DEATH.

152 D 53457

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bunn

(a) RESIDENCE. No. Johns Hopkins Hospital. ST.. WARD.

(Usual place of abode) (1647 N. Mount St)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	B.	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 4/29/21

7 AGE	Years	Months	Days	~~If LESS than 1 day, hrs.~~
Infant				50 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore- Md.

PARENTS

10 NAME OF FATHER Norman Bunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) - Md.

12 MAIDEN NAME OF MOTHER Josephine Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) - Md.

14 Informant J.O. Gamble Md.

(Address) Johns Hopkins Hospital.

Filed MAY 5 - 1921 ROBERT F. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/29 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/29, 1921, to 4/29/, 1921.

that I last saw h[illegible] alive on 4/29/, 1921.

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia (Heart beat perceptible for 50 minutes but no attempts at respiration) - Congenital atalectasis?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) E. L. Stone, M. D.

4/30 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER ADDRESS

Commissioner Health. MAY 4 1921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 53458

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Powell

(a) RESIDENCE. NO. (2115 Druid Hill Ave) ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 4/30/21

7 AGE	Years	Months	Days	If LESS than 1 day, 21 hrs.
	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ Child

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Clarence Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) ✓ Md.

12 MAIDEN NAME OF MOTHER Alethia Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ✓ Md.

14 Informant J. O'Lamble

(Address) Johns Hopkins Hospital

15 MAY 5 - 1921 ROBERT A KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/30, 1921, to 5/1, 1921,

that I last saw him alive on 5/1, 1921,

and that death occurred, on the date stated above, at 5-05 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) E. L. Stone. M. D.

5/1. 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAY 4 - 1921

20 UNDERTAKER

ADDRESS

Commissioner Health.

Par. Wm E. WOODALL

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53459

CERTIFICATE OF DEATH.

D 53459

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 Oak St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Amanda Warner

(a) RESIDENCE. NO. 2112 Oak St ST., WARD. Washington DC.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Wd.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Thomas Warner

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER John Wesley Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Lydia Shriver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Miss Nellie K Warner
(Address) Camp Humphreys Va.

15 Filed MAY 5 - 1921 ROBERT J. CRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to May 3, 1921, that I last saw her alive on May 2, 1921, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

Hypertension (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jane Eblaugh, M. D.

May 3, 1921 (Address) 700 N. W Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 5 1921

20 UNDERTAKER W M Stanton

ADDRESS 2238 N Mt Ave

mail 6/5/21

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53460

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 53460

REGISTERED NO. C.....

1-PLACE OF DEATH Linwood Ave & Fleet st.

CITY OF BALTIMORE (No. 1820 n Hope ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fredrick Scott.

(Residence in Baltimore: No. 1820. n Hope st

S~~t~~ 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, May 13, 1858
(Month) (Day) (Year)

7-AGE, 62 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). New York.

PARENTS.

10-NAME OF FATHER. John Scott.

11-BIRTHPLACE OF FATHER (State or Country). Pickua. Ohio

12-MAIDEN NAME OF MOTHER Helen Talmage

13-BIRTHPLACE OF MOTHER (State or Country). New York.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Scott

(Address) 1820 N. Hope st.

15- Filed MAY 5 - 1921 191.... ROBERT J. KRAUTER Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

5/5, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem.	5/7/21 192
20-UNDERTAKER	ADDRESS
George J. Ruth.	1735 Harford ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53461

REGISTERED NO. 79 D 53461

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #6-West-39th-Street. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Kirkland Weeks.

(a) RESIDENCE. No. #6-West-39th-Street ST., 12 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? 69 yrs. 9 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Rickards Weeks

6 DATE OF BIRTH (month, day, and year) July-7-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insuance Business.

(b) General nature of Industry, business, or establishment in which employed (or employer): Insurance.

(c) Name of employer: U.S. Casualty Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER John L. Weeks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norwich, Conn.

12 MAIDEN NAME OF MOTHER Margaret Kirkland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant Mrs. Lula R. Weeks (wife)
(Address) 6-W-39-St., City.

15 Filed MAY 5 - 1921 ROBERT E KRAUSE Registrar
Burial Permit 21681

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1921, to May 4, 1921, that I last saw h[illegible] alive on May 4, 1921, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Contrac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Standish McCleary, M. D.

19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
GreenMount Cemetery	May-6-21
20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53462

CERTIFICATE OF DEATH.

18-09 D 53462

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 Southern Ave ST.: Gardenville WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Leonard Quick

(a) RESIDENCE. No. 32 Southern Ave. ST., Gardenville WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Quick

6 DATE OF BIRTH (month, day, and year) Sept 22nd 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Railroads

(c) Name of employer B & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Gardenville Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Mrs Emma Quick (Address) 32 Southern ave. Balto. Md.

15 Filed MAY 5 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Oiled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1921, to May 3, 1921, that I last saw h alive on May 3, 1921 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Erysipelas of Face

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clarence Jones, M. D.

May 4 1921 (Address) 4746 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 6 1921
20 UNDERTAKER	ADDRESS
Theilk Lucas & Bro	Fullerton Md.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Teofil Sobus.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53463

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53463

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 S. Ann St.; 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teofil Sobus

(a) RESIDENCE. NO. 728 S Ann ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md

PARENTS

10 NAME OF FATHER Leon Sobus.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anula Bochanska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Leon Sobus. (Address) 728 S Ann St.

15 Filed MAY 5 - 1921 ROBERT F KRAUTHER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17

I HEREBY CERTIFY, That I attended deceased from May 2 , 1921 , to May 4 , 1921 , that I last saw h alive on May 3 , 1921 , and that death occurred, on the date stated above, at 5.45 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Kraus M. D.

5/7/21 (Address) 1841 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	May 5th 1921
20 UNDERTAKER M. F. Sadowski.	ADDRESS 905 S Ann

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sroka

17799 D 53464

HEALTH DEPARTMENT—CITY OF BALTIMORE D 53464

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: [illegible] WARD)

2-FULL NAME Julian Sroka

(a) RESIDENCE. No. 907 S Bouldin St. Highlandtown Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? 17 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 3. 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) ORB

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michael Sroka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Dzadzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Johns Hopkins Hospital Record
(Address)

15 Filed MAY 5 - 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 - 1921

17 I HEREBY CERTIFY, That I attended deceased from April 27. 1921. to May 4. 1921. that I last saw h[illegible] alive on May 4. 1921. and that death occurred, on the date stated above, at 12 15 am.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hugh J Morgan, M. D.

5/4, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	April 7 1921
20 UNDERTAKER Stephen J Fialkowski	ADDRESS 1000 Kenwood

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53465

CERTIFICATE OF DEATH.

64 D 53465

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 N. Wolfe St. ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Faulkner

(a) RESIDENCE. NO. 527 N. Wolfe ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eldridge R. Faulkner

6 DATE OF BIRTH (month, day, and year): July 3-61

7 AGE — Years: 59 Months: 10 Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: at Home

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Thos. Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Susan —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Eldridge Faulkner (Address): 527 N. Wolfe St.

15 Filed MAY 5 - 1921 BUREAU OF VITAL STATISTICS Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3. 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1910, to May 3rd, 1921, that I last saw her alive on May 3rd, 1921, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) yrs. mos. 3 hrs ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhages.

(duration) yrs. mos. 1/3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Hearne, M. D.

, 19 (Address) 2360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: May 6 1921

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Eutaw

(Signature of Local Registrar)

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53466

CERTIFICATE OF DEATH.

92 D 53466

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE: (No. 416 N Washington ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Hurst

(Residence in Baltimore: No. 416 N Washington St.; 46 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH, Dec 18, 1844
(Month) (Day) (Year)

7-AGE, 76 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rudolph Hurst

(Address) 2 W Franklin St

15- ROBERT J BRUCE

Filed MAY 5 — 1921 191... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 3 1921, that I saw him alive on May 2 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Cushman, M. D.

May 3, 1921 (Address) 310 S. Haslett Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Hill	May 6 1921
20-UNDERTAKER Philip Herwig	ADDRESS 2016 Aliceanna St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Original Missing)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D53467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ahrenburg

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town).....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country)

14
Informant .....
(Address)

15
Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h.... alive on ....., 19.....,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Traumatism

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. R. Imaley (Coroner) M. D.
....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Berry Run Cemetery	19
20 UNDERTAKER	ADDRESS
Jack Levis	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. Mehren Home

CITY OF BALTIMORE (No. 521 Aisquith St ST.: 10 WARD)

2-FULL NAME Sarah Ahrenberg

(Residence in Baltimore: No. 521 Aisquith St

17 D 53467

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

28

St.; yrs., mos. ds.)

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Every item of information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown ....., 1870
(Month) (Day) (Year)

7-AGE, 51 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- MAY 5 - 1921 ROBERT P. KRAUSE

Filed ..... 191.... Burial Permit Issued

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4, 1971
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

Duration (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Mesler M. D.
(Coroner.)

May 5, 1921. (Address) City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mehren Herring Run

DATE OF BURIAL, May 7, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

D 53468

Spec. 6-9118 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53468

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 129. W. Lee St. ST.: W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Lamartina

(a) RESIDENCE. No. 129 W. Lee St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? ___ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): April 19-21

7 AGE — Years | Months | ~~Days~~ | If LESS than 1 day, ...hrs. or ....min.

~~Days~~: 2 weeks.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Samuel Lamartina

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Alice Bonce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Mrs Samuel Lamartina 129. W. Lee St.

15 FILED: MAY 5 - 1921 ROBERT P. TRAUTEN Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-4 1921

17

I HEREBY CERTIFY, That I attended deceased from 5-2, 1921, to 5-4, 1921, that I last saw h alive on 5-4, 1921, and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? findings

(Signed) F. A. Theresa, M. D.

5-5 1921 (Address) 700 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden — DATE OF BURIAL: May 5 1921

20 UNDERTAKER: F. A. Kranz & Son — ADDRESS: 703 Hanover

IS A PERFECT RECORD. DATA should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. mation should be carefully supplied. AGE should be

Spec.—8-24-14—M. & T.—2000 Bks.

D 53469 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53469

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 W. Montgomery ST.; 72 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry C. Rossbach

(Residence in Baltimore: No. 58 W. Montgomery St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male (White) | 4-COLOR OR RACE, White | 5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, Aug 5, 1862
(Month) (Day) (Year)

7-AGE, 58 yrs. 9 mos. 1 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Plumber
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Phillip Rossbach

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theodor Rossbach

(Address) 1337 Herkimer

15- Filed MAY 5-1921 191.... ROBERT I KRAUTER Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 25 1921, to May 5 1921, that I saw h-er alive on May 3 1921, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

1 yr (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. E. Hewitt M. D.

May 5 1921 (Address) 835 E Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park | DATE OF BURIAL, May 7, 1921

20-UNDERTAKER F. A. Krause & Son | ADDRESS 703 Hanover

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53470

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53470

CERTIFICATE OF DEATH.

X 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Dawson

(a) RESIDENCE. NO. San Bernardino Calif WARD. San Bernardino, Calif.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Dawson

6 DATE OF BIRTH (month, day, and year) Dec 8—1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) California

PARENTS

10 NAME OF FATHER Y. E. Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Emma Kinnan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) California

14 Informant (Address) Johns Hopkins Hospital Robert P. Harrison,

15 Filed MAY 5 1921 19 Registrar

Burial Permit Clerk.

Via B. & O. Railroad - Escort Mrs. Eva Dawson
Santa Fe Railroad

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4— 1921

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1921, to May 4, 1921, that I last saw h.. alive on May 4, 1921, and that death occurred, on the date stated above, at 4½ 6D m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia - bron

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown —

Did an operation precede death? Yes Date of April 22 '21

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W E Hardy, M. D.

5-5, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
San Bernardino, Calif.	5/6, 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son, 506 N. Calvert St.	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53471

D 53471

CERTIFICATE OF DEATH.

29

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1213 Jame St ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Brigel

(a) RESIDENCE. NO. 1213 Jame St ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Brigel

6 DATE OF BIRTH (month, day, and year) Jan 2 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Brigel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Zinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Brigel
(Address) 1213 Jame St

15 Filed Robert P. Harrison, Registrar

MAY 5 - 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to May 3, 1921, that I last saw him alive on May 3, 1921, and that death occurred, on the date stated above, at 9 p m.

The CAUSE OF DEATH* was as follows:

Brights Disease.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surmise

(Signed) Raymond V. Adams, M. D.

May 5, 1921 (Address) Oakland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 6 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 D 53472

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Clark.

(Residence in Baltimore: No. 2501 Flat 5, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)..... on Tug Boat

9-BIRTHPLACE, (State or Country), Cumberland Md

PARENTS.

10-NAME OF FATHER, John C Clark

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ant Lennon

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Clark

(Address) 2501 Talbot St

15-

Filed ..... Robert L. Harrison. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., May 5, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by pistol shot (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Mary's Emmitsburg Md	May 7 ....., 19...
20-UNDERTAKER	**ADDRESS**
Wendel Undertaking Co	2161 Lanvale St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 5 1921 Burial Permit Clerk.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 53473

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53473

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1728 Linden Ave ST. 14 WARD)

2-FULL NAME Melcena E Ausdler

(a) RESIDENCE. NO. 1728 Linden Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 5 mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: (Ausdler) W^m H Ausdler

6 DATE OF BIRTH (month, day, and year): Nov 26. 1834

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
86	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rachael Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs John Suppl

(Address) 1728 Linden Ave

15 Filed ..... 19 .....

MAY 5-1921

Robert P. Harrison,

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1920, to May 4, 1921, that I last saw h W alive on May 4- 1921, and that death occurred, on the date stated above, at 8 25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of Hip

(duration) yrs. 11 mos. 4 ds.

18 Where was disease contracted if not at place of death? (Home)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Browne, M. D.

. 19 (Address) 1733 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: David Ridge — DATE OF BURIAL: May 6 1921

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette

MARGIN MUST BE RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53474 28 D 53474

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 Light ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice J. V. Miles

(a) RESIDENCE. NO. 827 Light ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Anthony M. Miles

6 DATE OF BIRTH (month, day, and year): Aug 23, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: John Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Mary Kate Piquette

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Anthony M. Miles

(Address) 827 Light St.

15 Filed MAY 5 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to May 2nd, 1921, that I last saw h.. alive on May 2nd, 1921, and that death occurred, on the date stated above, at 11:10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) four yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examination Tuberculosis T.B. Bacilli Present

(Signed) Charles O'Donovan, M. D.

19 21 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	May 7 1921
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53475

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 53475

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 3519 Benson ST.: 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles W Smith

(Residence in Baltimore: No. 3519 Benson St.; yrs. 1 mos. 8 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March 26 1920 (Month) (Day) (Year)

7 AGE: 1 yrs. 1 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Charles Smith

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Emma Young

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Smith

(Address) 3519 Benson

15

Filed MAY 5 1921, 19..

Robert P. Harrison,
Burial Permit Clerk.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May 4th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 27, 1921, to, May 4th 1921, that I saw h[illegible] alive on May 4th, 1921, and that death occurred, on the date stated above, at 7 15 P m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY) Capillary Bronchitis

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed), [illegible] M. D.

May 5, 1921 (Address) 846 W 36th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Marys Hampden — DATE OF BURIAL: May ..., 1921

20 UNDERTAKER: Chenowith & Son — ADDRESS: Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Richards)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 53476

152

D 53476

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. N. 36 Baldwin Ct ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Richards

(a) RESIDENCE. NO. N. 36 Baldwin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May. 2. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work In front yds

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Carroll Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Brown

(Address) N. 36 Baldwin St

15 Filed MAY 5-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 2nd, 1921, to May 4th, 1921

that I last saw him alive on May 4th, 1921,

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? No

(Signed) B. A. Liliedahl M. D.

5/5, 1921 (Address) N. 27 Union Sq

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	May 5 1921

20 UNDERTAKER ADDRESS

Chenoweth & Son Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Glenn O. Stevens)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53477 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53477

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Primrose Av ST.: 5th house East of Arlington Ave (WARD) 2

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Glenn Elder Stevens

(a) RESIDENCE. NO. Primrose Av. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 3 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	Wht	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER J Elder Stevens

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Oler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant J Elder Stevens
(Address) Primrose av

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr. 25, 1921, to May 4, 1921, that I last saw him alive on May 4th, 1921, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Marasmus & Marasmus.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Visible

(Signed) E L Smith, M. D.

May 4. 1921 (Address) 1605 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 6 1921
20 UNDERTAKER	ADDRESS
Horace H. Burgee	363 Fallo Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53478

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 53478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2209 Oak ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily R. Kirwan

(a) RESIDENCE. No. 2209 Oak ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Kirwan

6 DATE OF BIRTH (month, day, and year) Dec 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — —

(c) Name of employer — —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Kemphues

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Lilia L. Kirwan

(Address) 2209 Oak Street

15 Filed ..... 19 .....

Robert F. Harrison

Registrar

MAY 5-1921 Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1921, to May 4, 1921, that I last saw h[illegible] alive on May 3, 1921, and that death occurred, on the date stated above, at 1130 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Tumor.

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

5/5, 1921 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL May 7. 1921

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53479

CERTIFICATE OF DEATH.

X 120

D 53479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home Hope Retreat ST. 9th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ann E. Eckman

(a) RESIDENCE. No. 519 E. 21st St - Balto Md ST., WARD. Laurel, Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 8 ds. How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Mr Eckman

6 DATE OF BIRTH (month, day, and year) Jan 26th 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife of Telegrapher

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Laurel Md-

PARENTS

10 NAME OF FATHER Dan. B. Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fairfax Co Va

12 MAIDEN NAME OF MOTHER Ruth E. Hooker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md-

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Balto Md-

15 Filed MAY 5 - 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 26th, 1920, to May 3rd, 1921, that I last saw h[illegible] alive on May 3rd, 1921, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Syphilis, Complicated by Chr-Mitral Dis. of Heart-

over (duration) 0 yrs. 7 mos. 0 ds.

CONTRIBUTORY (Secondary) Hemorrhoids over (duration) 0 yrs. 7 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 4th, 1921 (Address) Mt Hope Retreat-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Laurel Md	May 6 1921
20 UNDERTAKER	ADDRESS
F.A. Krause & Son	703 Hanover

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Joseph M. Spriggs)

Spec.—8-24-14—M. & T.—2000 Bks.

D 53480

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53480

CERTIFICATE OF DEATH.

92

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1357 Woodyear ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph M. Spriggs

(Residence in Baltimore: No. 1357 Woodyear St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 17 1913
(Month) (Day) (Year)

7-AGE, 17 yrs. 11 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. City.

PARENTS.

10-NAME OF FATHER, Joseph Spriggs Sr.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mamie Reeder

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Spriggs Sr.

(Address) 1357 Woodyear

15- Robert P. Harrison,

Filed MAY 5 1921, 191.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4th, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3d 1921, to May 4th 1921, that I saw h— alive on May 3d 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

3

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Mitral

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) A. Lee Ellis M. D.

5/7, 1921 (Address) 724 Mosher

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, May 6th, 1921.

20-UNDERTAKER Hamme & Wright — ADDRESS 1364 W Cary

8.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53481

1920 D 53481

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 345 S. Stricker St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Elizabeth Ellis

(a) RESIDENCE. NO. 345 S. Stricker St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas W. Ellis

6 DATE OF BIRTH (month, day, and year) Apr. 22nd 1872

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER August C. Kuhl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Regina Grobb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Thomas W. Ellis 345 S. Stricker St.

15 Filed MAY 6 — 1921 [illegible] (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from 4/24/, 1921, to 5/4/, 1921, that I last saw h. ex alive on 5/3/21, 19..., and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Chr Hypertension

Chr Dyspepsia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) ...yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? [illegible]

(Signed) Leonard Key, M. D.

5/7, 1921 (Address) 910 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: May 7 1921

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 W. Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 53482

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 W. Mosher St. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward D. Clarke

(a) RESIDENCE. No. 1813 W. Mosher St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene Clarke

6 DATE OF BIRTH (month, day, and year) Oct. 9th 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Foreman)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Clarke

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Isabelle Winchester

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Geo. E. Brewer
(Address) 1813 W. Mosher St.

15 Filed MAY 6 - 1921 19 [illegible] KRAUTER Registrar

Burial Permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 19 21

17 I HEREBY CERTIFY, That I attended deceased from May 3 1921, to April 18 1921, that I last saw him alive on May 3 1921, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Stomach Carcinoma
Nephritis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dyspepsia Hist

(Signed) John H. Cary, M. D.

19 (Address) 101 N. Cary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	May 6 1921

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X53 D 53483

REGISTERED NO.

1-PLACE OF DEATH Howard A. Kelly Hospital

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Jessie Baxter

(a) RESIDENCE. NO. Fort Laramie, Ohio. ST.; WARD. Ft Laramie Ohio

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr. William M. Baxter.

6 DATE OF BIRTH (month, day, and year) Oct 25, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Catawba County
(State or country) North Carolina

PARENTS

10 NAME OF FATHER Mr. Jay Thomason

11 BIRTHPLACE OF FATHER (city or town) Catawba County
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Jane Smith.

13 BIRTHPLACE OF MOTHER (city or town) Lincoln County
(State or country) N.C.

14 Informant Mrs M Baxter
(Address) Ft. Laramie Ohio

15 Filed ....., 19 .....

MAY 6- 1921

[illegible] KRAUTER
[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1921

17 I HEREBY CERTIFY, That I attended deceased from 1 P.M. May 5, 1921, to 11.20 p.m. May 5, 1921,
that I last saw h.r alive on May 5, 1921,
and that death occurred, on the date stated above, at 11.20 p.m.

The CAUSE OF DEATH* was as follows:

Hodgkin's disease

(duration) ....yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) none

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert E. Fricke, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newton North Carolina	May 6 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53484

CERTIFICATE OF DEATH.

4 29 D 53484

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 615 Caden ady ST.: 4 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Smith

(Residence in Baltimore: No. 615 Caden ady St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE, 27 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress'
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md'

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Pa ave

15-

Filed MAY 8 1921, 191 [illegible] Registrar.

Burial [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3rd, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or Inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or Inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy disease of the heart

(Duration) Dont Know' mos. ds.

CONTRIBUTORY (Secondary) Dont Know'

(Duration) yrs. mos. ds.

(Signed) H K Gorman M. D. (Coroner.)

5-6, 1921. (Address) 11 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, May 8, 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19 H. P. Co.—1000 Bks.

D 53485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wallace

(a) RESIDENCE. No. 1002 Russel Terrace ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Jim Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Isabelle Coats

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records
(Address): M.T.H.

15 Filed MAY 6-1921 19 ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1921, to May 3, 1921,

that I last saw him alive on May 3, 1921,

and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous broncho pneumonia (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. H. Falkenau, M. D.

5-3-21. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Burns Hill Sun'd	May 6 21
20 UNDERTAKER: Daniel Carbi	ADDRESS 716 Penna ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 53486

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View. ST. 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Blackowicz

(a) RESIDENCE. NO. Unknown 835 S Bond ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records, (Address) New City Hospital.

15 MAY 6-1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1921 to May 5, 1921, that I last saw her alive on May 5, 1921, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia + Cachexia (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Section of tissue

(Signed) F. A. Holden, M. D.

5/5/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer bem	May 7" 1921
20 UNDERTAKER	ADDRESS
M F Sadowski	905 S Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53487

CERTIFICATE OF DEATH.

120 ✓

REGISTERED No. C D 53487

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Roland Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Rose Albaugh

(Residence in Baltimore: No. 6 Roland Ave St.; 70 yrs., 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, March 8, 1851.
(Month) (Day) (Year)

7-AGE, 70 yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Samuel Linthicum

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Kirkwood

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Albaugh

(Address) 6 Roland Ave

15- MAY 6 - 1921 ROBERT I KRAUTER
Filed....., 191.... Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1921, to May 4 1921, that I saw h[illegible] alive on May 4 1921, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Walter A. Coe M. D.

5/6, 1921. (Address) 543 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, May 7, 1921.

20-UNDERTAKER Chas. E. Franck ADDRESS 802 Madison Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MH V. 1183

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53488

CERTIFICATE OF DEATH.

79 D 53488

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S. Washington ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Constantina Hays

(a) RESIDENCE. No. 19 S. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John J. Hays

6 DATE OF BIRTH (month, day, and year): March 8/1860

7 AGE: Years 61; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jacob Eckart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER: Caroline Schilling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Mr. John Hayes
(Address): 19 S. Wash. St.

15 Filed MAY 6-1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-5 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-3, 19 21, to 5-5, 19 21, that I last saw her alive on 5-4, 19 21, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis Syphilitic, Hysterectomy
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) T. T. Lukaszka, M. D.

5, 1921 (Address) 1500 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: May 9 1921

20 UNDERTAKER: Jos. J. Herr — ADDRESS: 156 N. Liberty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53489

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 924 N. Central Ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Klein

(a) RESIDENCE. No. 924 N. Central Ave ST., 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or divorced
(or) WIFE of the late Martin Klein

6 DATE OF BIRTH (month, day, and year) Dec. 27 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Veit ~~Klein~~

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Miss Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr John B. Klein
(Address) 924 N. Central Ave

15 Filed MAY 6 1921 19 ROBERT A. CRAUTER Registrar
Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1921

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1921, to May 5, 1921, that I last saw h[er] alive on May 5, 1921, and that death occurred, on the date stated above, at 11 40 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Senility

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ....Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry H. Weinberger, M. D.

May 5, 1921 (Address) 724 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 9 1921
20 UNDERTAKER	ADDRESS
Henry Houck & Son	1301 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53490 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53490

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 N. Eden St. 5 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A Schulz

(a) RESIDENCE. No. 410 N Eden St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 5 mos. 20 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Architect

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Hermann Schulz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Michel

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Herman Schulz
(Address) 410 N. Eden st

15 Filed MAY 6-1921 ROBERT P. LATIMER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28. 1921, to May 4, 1921, that I last saw him alive on May 4, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? exam of sputum

(Signed) Robt. J. O'Brien, M. D.

5-5, 1921 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	May 7th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53491

CERTIFICATE OF DEATH.

120 D 53491

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 522 Somerset St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Moore

(Residence in Baltimore: No. 522 Somerset St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col.	Widow

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE	If LESS than 1 day,
62 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Housework

9-BIRTHPLACE, (State or Country), born in Baltimore

PARENTS.

10-NAME OF FATHER, James Wilson

11-BIRTHPLACE OF FATHER (State or Country), West India Island

12-MAIDEN NAME OF MOTHER, Harriet Brailsford

13-BIRTHPLACE OF MOTHER (State or Country), born in Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Coleman

(Address) 522 Summerset St

15-

Filed MAY 6 - 1921, 191.... BOARD OF HEALTH ... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

May 24, 1921. (Address) 2738 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
National Cem	May 6, 1921
20-UNDERTAKER	ADDRESS
Mrs R A Elliott	1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53492

CERTIFICATE OF DEATH.

79 D 53492

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 E. Fairmount ~~St.~~ Av. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Simpson

(a) RESIDENCE. No. 1820 E. Fairmount ~~St.~~ Av. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Middanstt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jacob H. Simpson 1820 E. Fairmount Av.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8 1921 to May 5th 1921, that I last saw h~~e~~r alive on May 5 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocorditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) 1 yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) M. Abramowitz, M. D.

19 (Address) 1707 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Hebrew Cem	5/6 1921

20 UNDERTAKER Jack Ledrs ADDRESS 1411 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Flamenbaum.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53493

CERTIFICATE OF DEATH.

151 D 53493

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1007 E Balto St ST.: 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Flamenbaum

(Residence in Baltimore: No. 1007 E. Balto St St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) \

6-DATE OF BIRTH, May 4, 1921
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds.

If LESS than 1 day, 3 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work \
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Max Flamenbaum

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Famie Fuchman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto St

Rd MAY 6-1921 ROBERT I KRAUTER

Filed....., 191.. Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5/ 21, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

congenital Debility

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration)....yrs....mos....ds.

(Signed) (Coroner) M. D.

5/6, 191.. (Address) 1500 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pikesville Rosedale

DATE OF BURIAL, May 6, 1921

20-UNDERTAKER, Jack Lewis

ADDRESS 1411 E Balto

Spec.—5-19-13—M. & T.—500 Bks.

Maria H Kelly.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53494

CERTIFICATE OF DEATH.

79 D 53494

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 Orleans ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Theresa Kelly

(Residence in Baltimore: No. 1822 Orleans St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April (Month) ... (Day) ..., 1891 (Year)

7-AGE, 47 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Austin Culley.

11-BIRTHPLACE OF FATHER (State or Country), Richmond Va.

12-MAIDEN NAME OF MOTHER Martha Culley.

13-BIRTHPLACE OF MOTHER (State or Country), Richmond. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlie Kelly.

(Address) 1822 Orleans St.

MAY 6 - 1921

Filed ..., 191... ROBERT F KRAUTER

Burial Permit Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 7 1921, to May 4 1921, that I saw h[illegible] alive on May 3 1921, and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Valvular disease

(Duration) ... yrs. ... mos. 1 ds.

(Signed) H J Berry M. D.

May 5, 1921 (Address) 6770 Reisterstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery May 7 DATE OF BURIAL, 1921

20-UNDERTAKER Wilkes Davis. ADDRESS 413 N Eden St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53495

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53495

CERTIFICATE OF DEATH.

REGISTERED NO. 64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Esplanade Apt Entrance Park Ave. (ST.) (WARD.)

2-FULL NAME Catherine Matthews

(a) RESIDENCE. NO. 1805 Inc Collock st ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE about 70 — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Archie Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Perkins

(Address) 1805 Inc Collock st

15 Filed MAY 6 1921 ROBERT T. HAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to May 4, 1921, that I last saw h alive on May 3, 1921, and that death occurred, on the date stated above, at 9 00 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) James Frederick M. D.

May 6. 1921 (Address) 10 S St Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ind Auburn	April 6 1921
20 UNDERTAKER Geo W Holland	ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 53496

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Washington

(a) RESIDENCE. NO. 903 E. Sharp St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Washington

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
44				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bar-Tender

(b) General nature of industry, business, or establishment in which employed (or employer) 44

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hospital Records (Address)

15 Filed MAY 6 1921 ROBERT E. LAMBERT Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1920, to May 4, 1921, that I last saw h. alive on May 4, 1921, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & serologic

(Signed) Geo. C. McElderry, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 8 1921

20 UNDERTAKER R C Groth ADDRESS 1406 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53497

D 53497

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1941 Ramsay ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth D. Hutchinson

(a) RESIDENCE. NO. 1941 Ramsay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 2 mos. 26 ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas K. Hutchinson

6 DATE OF BIRTH (month, day, and year) Feb. 8th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Kunstland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Loutta Lehman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Thomas K Hutchinson (Address) 1941 Ramsay St.

15 MAY 6 - 1921 19... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1921.

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 4, 1921, that I last saw ... alive on May 4, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Condition

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James K. Lashburg M. D.

5/5, 1921 (Address) 1724 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	May 7 1921

20 UNDERTAKER George L. Schwat & Bro ADDRESS 2101 Eutaw Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53498 — 7186 — D 53498

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. Barge Northern #41 Curtis Bay. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Riley.

(Residence in Baltimore: No. Salem Mass. St.; yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1 (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Donkey man.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Chicago, Ill.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Capt. Elmer Gammon.

(Address) Barge Northern #41 Curtis Bay.

15- Filed MAY 6 - 1921 191 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3rd. 1921. (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental fracture of the skull.
Struck on the head by a winch on a barge.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Otto M. Rossbach M. D.
(Coroner.)

May 5th, 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence Salem Mass.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	MAY 6 1921

20-UNDERTAKER JOHN F. DENNY ADDRESS 715 LIGHT ST

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53499 28 D 53499

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 N. Bradford ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Schmidt

(a) RESIDENCE. NO. 1633 N Bradford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Two yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sewing

(b) General nature of industry, business, or establishment in which employed (or employer) at Lamb. Bros.

(c) Name of employer — " "

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Neubauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mother Emma Schmidt 1633 N Bradford

15 FILED MAY 6-1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5-6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 5, 1921, that I last saw h.d alive on May 5, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(about)
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms

(Signed) [illegible] M. D.

5-7, 1921 (Address) 1 E Fulton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dulaney Chapel	5 7 1921

20 UNDERTAKER Thos Chas A & Robt E Hamilton ADDRESS 450 Pulaski

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53500 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

120 D 53500

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 223 N. Curley ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara A Bopp.

(a) RESIDENCE. No. 223 N Curley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7Yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A Bopp.

6 DATE OF BIRTH (month, day, and year) Aug 30 - 1878

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Bolek.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Kalec

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George A Bopp. (Address) 223 N Curley St

15 Filed MAY 6 - 1921 19 ROBERT J KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to May 4, 1921, that I last saw h.. alive on May 4, 1921, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

Renal. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Manic Depressive Insanity

Renal. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Leslie Ewell, M. D.

, 19 (Address) 905 N Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	5-7th 1921
20 UNDERTAKER E & B Hartz	ADDRESS 115 E West St

Burial Permit Clock

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53501

D 53501

CERTIFICATE OF DEATH.

8-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1230 Mc Culloh ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Henson

(a) RESIDENCE. No 1230 Mc Culloh ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 9, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER J Wesley Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Annie Henson

(Address) 1230 Mc Culloh St.

15 Filed MAY 6-1921 ROBERT P. BEAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6 1921

17

I HEREBY CERTIFY, That I attended deceased from 4-27, 1921, to 5-6, 1921, that I last saw her alive on 5-5, 1921, and that death occurred, on the date stated above, at 2-A. m.

The CAUSE OF DEATH* was as follows:

1st Whooping Cough.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) William A. Harris, M. D.

, 19 (Address) 1200 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 6 1921
20 UNDERTAKER	ADDRESS
John M. Johnson	Etting St

Spec.—6-9-19—H. P. Co.— 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53502

D 53502

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 E. Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver J. Doyle

(a) RESIDENCE. No. 1825 E. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piledriver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Raymond Concrete Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John E. Doyle

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Kirschbaum

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant Sophie Gollenberg
(Address) 2218 Jefferson St

15 Filed MAY 6-1921 ROBERT J. KRAUTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17

I HEREBY CERTIFY, That I attended deceased from April 7, 1921, to May 3, 1921, that I last saw h— alive on May 3, 1921, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T. Avery M. D.

19 (Address) 1623 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	May 8, 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	1310 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53503

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 McCabe av ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Holmes Norris

(a) RESIDENCE. NO. 722 McCabe av ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 17. 1898 ~~1899~~

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
23	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer Penna R R

9 BIRTHPLACE (city or town) (State or country) Allegheney Pennsylvania

PARENTS

10 NAME OF FATHER Joshua E. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Marion E. Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant Joshua E. Norris (Address) 722 McCabe av

15 Filed Robert P. Harrison, Registrar

AY 6 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1921

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 1920, to May 5, 1921, that I last saw h... alive on May 4, 1921, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mon. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 6 mon. ds.

18 Where was disease contracted if not at place of death? not Known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms

(Signed) ... M. D.

May 7, 1921 (Address) 1 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 7 1921
20 UNDERTAKER	ADDRESS
John B. Spencer	1025 N Caroline St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53504

28-010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 620 E. Washington ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie B Harris.

(a) RESIDENCE. No. 620 E. Washington ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 10 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George M. Harris.

6 DATE OF BIRTH (month, day, and year) June 18 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Madelud.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Schevitzka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George M. Harris
(Address) 620 E. Washington St.

15 Filed MAY 6 1921, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to May 4, 1921, that I last saw her alive on May 3, 1921, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary).

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Influenza

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John H. Ruhlmann, M. D.

, 19 (Address) 1709 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 7 1921

20 UNDERTAKER Lilly & Zuler

ADDRESS 4008 Wash Blvd

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53505 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53505

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1127 N Gilmor ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina Elizabeth Abbott.

(a) RESIDENCE. NO. 1127 N Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
F	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph L Abbott

6 DATE OF BIRTH (month, day, and year) Oct 1 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md
(State or country)

PARENTS

10 NAME OF FATHER Wm H. Hoffman

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Helena E Brown

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Wm E. Hoffman
(Address) 1127 N Gilmor St

15 Filed MAY 6 - 1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1921

17

I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 5, 1921, that I last saw h alive on May 5, 1921, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia & Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urea, Kidney Tests

(Signed) Thomas J. Talbott, M. D.

, 19 (Address) Marlborough Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 7 1921
20 UNDERTAKER	ADDRESS
Putnam & Rose	1223 W Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53506

D 53506

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Conner

(a) RESIDENCE. No. Unknown ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Pat Conner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown 5/3/21

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed Robert P. Harrison, Registrar

MAY 6-1921

Burial (Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921 to May 3, 1921, that I last saw h... alive on May 2, 1921, and that death occurred, on the date stated above, at 8:10 A. m.

The CAUSE OF DEATH* was as follows:

Abscess of Stomach

(duration) yrs. mos. 40 ds.

CONTRIBUTORY (Secondary) Bronchos-Pneum 6

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes here

Did an operation precede death? yes Date of 3-24-21

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) J. A. Holden, M. D.

(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS MAY 6 - 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53507 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53507

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Spalding & Denmore Aves. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Kelly

(a) RESIDENCE. NO. Spalding & Denmore Aves ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 52 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Elizabeth Armstrong

6 DATE OF BIRTH (month, day, and year) June 23, 1845

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President

(b) General nature of industry, business, or establishment in which employed (or employer) National Building

(c) Name of employer Supply Company

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER ----- Manion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Kelly Jr.
(Address) North Ave. & Oak Street

15 Filed MAY 6-1921, 19 Robert F. Carriber, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4. 1921.

17 I HEREBY CERTIFY, that I attended deceased from Jany 11, 1921 to May 3. 1921, that I last saw h in alive on May 3. 1921, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dyspnoea

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Cannot say

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Usual Signs

(Signed) Ralph F. Hardigh, M. D.

, 19 (Address) 1111 E. Eager.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery, Govans	5/7, 21
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

WRITE IN PERMANENT BLACK OR BLUE-BLACK INK

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53508

D 53508

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Brandt

(a) RESIDENCE. NO. 412 W. 24th St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Conrad Brandt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Vogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Conrad Brandt
(Address) 412 W 24th St

15 Filed MAY 6 1921 19 .... Registrar Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1921, to May 6, 1921, that I last saw him alive on May 6, 1921, and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Empyema

(duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial In-
sufficiency (duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home 412 W. 24th St.

Did an operation precede death? Yes Date of March 26, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cyrus D. Horne M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	May 7 1921
20 UNDERTAKER	ADDRESS 1339
E. Schloman & Son	Pennsylvania

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53509

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 53509

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhemina Hansworth (Lewis)

(a) RESIDENCE. No. 450 E. Federal st. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 years yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Willis Hansworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Lucinda Dunkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address) M. T. H.

15 DATE RECEIVED MAY 6, 1921

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to May 5, 1921, that I last saw her alive on May 4, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, T. B. in sputum

(Signed) L. N. Fahndrich, M. D.

5-5-21. 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn Cemetery	1921
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Madison st

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53510

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53510

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1304 St Matthews St ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Hill

(a) RESIDENCE. No. 1304 St. Matthews ST., ... WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Female	Colored	Married

5a If married, ~~widowed~~, or divorced HUSBAND of (or) WIFE of Charles Hill

6 DATE OF BIRTH (month, day, and year) Nov 25. 78

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Ben. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Rachel Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis

11 Informant (Address) Wm. H. Lyons 1304 St. Matthew St

15 Filed May 6 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 5 1921, that I last saw her alive on May 5 1921, and that death occurred, on the date stated above, at 11.55 A.m.

The CAUSE OF DEATH* was as follows:

apoplexy

Broncho Pneumonia (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. G. Kennard, M. D.

5-5. 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 7 1921

20 UNDERTAKER ADDRESS

Jas. M. Skinner 1625 E. Mad. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53511

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53511

CERTIFICATE OF DEATH.

92-146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. Eye Ear & Throat Hospital ST. WARD)

2-FULL NAME Samuel Black

(a) RESIDENCE. No. 1528 Eastern ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 13 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marya. Blak

6 DATE OF BIRTH (month, day, and year) Oct. 28- 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Woodworker

(b) General nature of Industry, business, or establishment in which employed (or employer): Mic Work Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER Michal Blak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Marya Slovik

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant Marya Blak

(Address) 1528. Eastern ave

15 Filed MAY 6 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1921.

17

I HEREBY CERTIFY, That I attended deceased from Apr. 16, 1921, to May 5, 1921.

that I last saw h.. alive on May 5 1921.

and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Septic Thrombosis of Lateral Sinus due to Chronic Mastoiditis

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Septic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Apr. 12, 21.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Kyrider, M. D.

, 19 (Address) 1908 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	May 9 1921
20 UNDERTAKER	ADDRESS
William Fialkowski	18 Eastern ave

MARRIAGE RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOTE B.—WRITE PLAINLY, WITH UNFADING INK.—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53512 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53512

CERTIFICATE OF DEATH.

47

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. Bruce St.: 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rosie Dorsey

(a) RESIDENCE. No. 18 N. Bruce St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of married

6 DATE OF BIRTH (month, day, and year) March 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co Md

PARENTS

10 NAME OF FATHER John Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co

12 MAIDEN NAME OF MOTHER Rosie Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ivy Allen

(Address) Robert P. Harrison, 15 W. Druid Pl

15 Filed MAY 6-1921 19 (Burial Permit Clerk) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1921, to May 2, 1921, that I last saw her alive on May 2, 1921, and that death occurred, on the date stated above, at 330A m.

The CAUSE OF DEATH* was as follows:

Endocarditis ? 64

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Ilse Nadelmann, M. D.

May 5, 1921 (Address) 34. So Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dawsonville Q.G. Co Md	May 7 1921
20 UNDERTAKER	ADDRESS
Brown and Freeland	114 N. Schroeder

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Rheumatic fever

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53513 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53513

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 N Streeper ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalene Phillips

(a) RESIDENCE. No. 123 N Streeper ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 24. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER George Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Cecilia Knopp

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant George Phillips (Address) 123 N Streeper

15 Filed MAY 7-1921 19 Registrar Robert F. Harrison.

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 6, 1921, that I last saw h.e alive on May 6, 1921, and that death occurred, on the date stated above, at 2.0 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wenton, M. D.

(Address) John Binny

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 6 1921
20 UNDERTAKER	ADDRESS
Wendell Myers Son	3711

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53514

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53514

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 235 S. Washington ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine M. Lorenz

(a) RESIDENCE. No. 235 S. Washington ST. 2 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 4th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Aloys Lorenz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Marie Senn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Aloys Lorenz

(Address) 235 S. Washington St

15 Filed MAY 7 1921 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 6, 1921, that I last saw her alive on May 6, 1921, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis
Neonatorum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Joseph C. Eisenberg, M. D.

May 6, 1921 (Address) 2201-03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	May 7th 1921
20 UNDERTAKER Lilly + Zeiler	ADDRESS 403 S. Wolfe St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53515

CERTIFICATE OF DEATH.

REGISTERED NO. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Johnson

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work School-Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edward Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed MAY 7-1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 19 21

17 I HEREBY CERTIFY, That I attended deceased from February 28, 19 21, to May 5, 19 21,
that I last saw her alive on May 4, 19 21,
and that death occurred, on the date stated above, at 5:05 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Sputum examination

(Signed) B Herman, M. D.

5/5/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL
Melvale Home May 7 21

20 UNDERTAKER ADDRESS
A. S. Marshall 3539 Fall Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53516

D 53516

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 N Stricker ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caspar Mathias Theel

(a) RESIDENCE. No. 1640 N Stricker ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Theel

6 DATE OF BIRTH (month, day, and year) April 6 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchmaker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 06

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mathias Theel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Luckum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry Theel

(Address) 1140 N Stricker St

15 Filed ....., 19 Robert P. Harrison, Registrar

MAY 7-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920 to May 5, 1921, that I last saw him alive on May 4, 1921, and that death occurred, on the date stated above, at 1:20 A. M.

The CAUSE OF DEATH* was as follows:

General Bad condition Senility & chronic Nephritis, 4 months

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Uraemic Poisoning 4

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C H Davis, M. D.

, 19 (Address) 2108 Brookfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	May 9 1921
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr Charles R Dorr
2108 Bromfield ave
Chronic Nephritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53517

D 53517

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 503 N Stricker ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Pensmith

(a) RESIDENCE. No. 503 N. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J Pensmith

6 DATE OF BIRTH (month, day, and year) Apr. 19 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frankfort
(State or country) Germany

PARENTS

10 NAME OF FATHER George Renz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Maidel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Laura V. Marks
(Address) 503 N Stricker St

15 Filed 19 Robert P. Harrison, Registrar
MAY 7 1921 Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17 I HEREBY CERTIFY, That I attended deceased from ~~June 5~~, 1921, to May 4, 1921, that I last saw h~~e~~r alive on May 4, 1921, and that death occurred, on the date stated above, at ~~4~~ 8.02 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) C. M. Limperis, M. D.

19 21 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 7 1921
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	North & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. F. Dunstan
no hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53518

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53518

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 N. Washington ST., 8th WARD)

2-FULL NAME Annie M. Mullen

(a) RESIDENCE. No. 1223 N. Washington ST., 8th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. 1 ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~last~~ WIFE of Walter A. Mullen

6 DATE OF BIRTH (month, day, and year) Nov 3 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bath. Md.

PARENTS

10 NAME OF FATHER Wm. C. Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bath. Md.

12 MAIDEN NAME OF MOTHER Laura M. Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bath. Md.

14 Informant Walter A Mullen

(Address) 1223 N Washington St

15 Filed MAY 7 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4. 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1920, to May 4, 1921, that I last saw h 81 alive on " 3. 1921, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Trial for sugar

(Signed) Sol. H. Hartman, M. D.

, 19 (Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dallsprings	May 7. 1921
20 UNDERTAKER	ADDRESS
Robt J Turner Inc	1424 Bway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53519

D 53519

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 5011 Beauregarde Ave St. 27th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Priscilla Parker

(Residence in Baltimore: No. 5011 Beauregarde ave St.; 1 yrs., 6 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fml

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Jan 24, 1919. (Month) (Day) (Year)

7-AGE, 1 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Staker Parker

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Elsey Graham

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Staker Parker

(Address) 5011 Beauregard ave

15-

Filed ....., 191.....

Robert F. Harrison,
Burial Permit Clerk.

Registrar.

MAY 7-1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4 1921, to May 5 1921, that I saw her alive on May 5 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Membranous Croup

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. A. Duncan M. D.

May 5, 1921 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. dy. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cockeysville DATE OF BURIAL, MAY 7 1921, 191...

20-UNDERTAKER James A Dennis ADDRESS 1303 Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53520

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53520

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 3 WARD)

2-FULL NAME Frederick T Bayer

(a) RESIDENCE. No. 119 S. Bethel St ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? 4 yrs. 5 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22 - 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George M. Bayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Frances T. Staag

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant George M. Bayer
(Address) 119 S Bethel St

15 Filed MAY 7 1921, 19 Bert J. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1921, to May 6, 1921, that I last saw her alive on May 6, 1921, and that death occurred, on the date stated above, at 1.20 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor

Unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Fatty
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. B. McElwain, M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 10 1921
20 UNDERTAKER	ADDRESS
Henry Lutz	1007 N. Bond

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53521

CERTIFICATE OF DEATH.

1054

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincents Infant Asylum WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Geyer

(a) RESIDENCE. No. St. Vincents Infant Asylum WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Katherine Geyer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Stanley W. Mathews
(Address) St. Vincents Infant Asylum

15 Filed MAY 7 - 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1921, to May 1, 1921, that I last saw her alive on May 1, 19..., and that death occurred, on the date stated above, at 11.45 p m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Weight 5 lb. at Birth)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Chas P Blanchard M. D.

May 2 1921 (Address) 1504 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 7 1921
20 UNDERTAKER	ADDRESS
Martin Faherty & Son	827 W Pratt St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53522 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3702 Fernwood Ave ST.: 26 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adolph Berg

(Residence in Baltimore: No. 3702 Fernwood Ave St.; yrs., (1) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, July 8, 1862 (Month) (Day) (Year)

7-AGE, 58 yrs. 9 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Propieter
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant Keeper

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Jacob Berg

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna M. Fischer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Berg

(Address) Herman St. Cypress Ave

15- Brroklyn N.Y.

Filed ..... 191 Robert P. Harrison, Registrar.

MAY 7 - 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6/ 21 (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) and that said deceased came to His death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

5/7 (Signed) Adolph Berg M. D.

(Coroner.)

191... (Address) 1800 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Brooklyn N. Y.

19-PLACE OF BURIAL OR REMOVAL, Calvary Cem. Brooklyn N.Y. DATE OF BURIAL, May 10/21 19...

20-UNDERTAKER Lilly & Zeller ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53523

CERTIFICATE OF DEATH.

REGISTERED NO. 192

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2503 Eastern Ave ST. 1 WARD)

2-FULL NAME Marie J Brandyis

(a) RESIDENCE. NO. 2503 Eastern Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Klaas Brandyis

6 DATE OF BIRTH (month, day, and year) Oct 5 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Cornelius Ashuiman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Marie Vermer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Klaas Brandyis (Address) 2503 Eastern Ave

15 Filed MAY 7-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 19 1921 to May 6 1921.

that I last saw her alive on May 5 1921,

and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. J. Meer, M. D.

, 19 (Address) 408 S. Ch. St. Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemt	May 9 1921

20 UNDERTAKER Wm Cook 502 E Baltimore ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53524

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

92nd D 53524

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 209 S Bouldin ST. 26 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Zentgraf

(Residence in Baltimore: No. 209 S Bouldin St.: 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Dec (Month) 9 (Day), 1853 (Year)

7-AGE: 67 yrs. 4 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Md Baltimore County

PARENTS

10-NAME OF FATHER: Foster

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) August Zentgraft

(Address) 209 S Bouldin

15

Filed MAY 7 1921, 19.. Robert P. Harrison,

REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 6 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1921, to May 6, 1921, that I saw her alive on May 5, 1921, and that death occurred, on the date stated above, at 2:40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Exact number of days not known.

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. L. Engram M. D.

May 6, 1921 (Address) 2439 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: May 9, 1921

20-UNDERTAKER: Harry A Wilson

ADDRESS: 531 N Howard St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 53525

1PLACE OF DEATH

CERTIFICATE OF DEATH

51 D 53525

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 327 S Payson ST. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Elderkin

(Residence in Baltimore: No. 327 S. Payson St. 52 yrs. 6 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Oct (Month) 25 (Day), 1869 (Year)

7-AGE: 52 yrs. 6 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of indu try, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Jacob Dallte

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Amelia Hess

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Elderkin

(Address) 329 S Payson St.

15. Robert P. Harrison,
Filed MAY 7 1921, 191
Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 6 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1921, to May 6, 1921, that I saw her alive on May 6th, 1921, and that death occurred, on the date stated above, at 1 Pm.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) Interstitial Nephritis Exophthalmic Goiter

(Duration) 2 yrs. 5 mos. ..... ds.

(Signed) W H Brueckleen M. D.

May 7, 1921 (Address) 1328 S Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: May 9, 1921

20-UNDERTAKER: Joseph Leyer — ADDRESS: 1000 W North

*B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 7 1921

(Benj. F. Dyson)

D 53526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53526

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Wilhelm ~~Station~~ ~~ages~~ n/St. 13 WARD) 175-003

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME ~~Benj~~ F. Dyson

(Residence in Baltimore: No. 2514 Woodbrook ave St.; yrs. 7/12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male.	White	Married

6-DATE OF BIRTH, ... Aug. (Month) 25 (Day), 1869 (Year)

7-AGE, 51 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Motorman W. Bra
(b) General nature of industry, business, or establishment in which employed (or employer)..... R.R.

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas E. Dyson

(Address) 2514 Woodbrook ave

15-

Filed ..... 191 Robert P. Harrison
Registrar.

MAY 7-1921

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & internal injuries his accident W. Bra R.R. at Wilhelm Sta a few miles

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Grossmark M. D. (Coroner.)

5-7, 1921. (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mount Ridge	May 7, 1921
20-UNDERTAKER	ADDRESS
Josiah Dyer	1600 W North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53527 D 53527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED NO. C 104

CITY OF BALTIMORE: (No. 739 E Fort Ave. St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert H Allen.

(Residence in Baltimore: No. 739 E Fort Ave St.; yrs. 1 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March 26, 1920
(Month) (Day) (Year)

7-AGE, yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Allen

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Sners

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Allen

(Address) 739 E Fort Ave

15- Filed MAY 7 1921, 191... Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2nd 1921, to May 6 1921, that I saw h[illegible] alive on May 5 1921, and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

I.L.C.O. Co. Cholelithiasis

Acute

Peritonitis Secondary

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. mos. 4 ds.

(Signed) H. H. Leonard M. D.

4/6/21, 191... (Address) 423 E Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	5-7, 191...
20-UNDERTAKER	ADDRESS
E and S Hale	115 E Monte

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53528 D 53528

CERTIFICATE OF DEATH.

1139

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE: (No. 430 East Fort Avenue ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Ursula Zimmerman

(Residence in Baltimore: No. 430 East Fort Avenue St., 30 yrs., 7 mos., 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~. (*Write* the word.) Married

6-DATE OF BIRTH, September 17, 1890
(Month) (Day) (Year)

7-AGE, 30 yrs. 7 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles S. Coon

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Sarah Smith

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Beaumont

(Address) 430 East Fort Avenue

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MAY 7 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1921, to May 5 1921, that I saw h[illegible] alive on May 5 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(Duration) yrs. mos. 28 ds.

(Signed) H. M. Alexander M. D.

5/7, 1921. (Address) 1022 West Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	May 7, 1921.
20-UNDERTAKER	ADDRESS
Jonah Ryan	1600 W North

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53529 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53529

CERTIFICATE OF DEATH.

REGISTERED No. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 306 W Belvedere Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret M. Fraimie

(Residence in Baltimore: No. 306 W Belvedere Ave St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, January 18, 1861
(Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Fraimie

11-BIRTHPLACE OF FATHER (State or Country), Germainy

12-MAIDEN NAME OF MOTHER Margaret Maisel

13-BIRTHPLACE OF MOTHER (State or Country), Germainy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Fraimie

(Address) 3712 Forest Park Ave

15-

Robert P. Harrison,

Filed ..... 191.....

Registrar.

MAY 7-1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Knowles M. D.
(Coroner.)

May 7, 1921 (Address) 232 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	May 9th, 1921
20-UNDERTAKER	ADDRESS
Henry J. Jenkins & Son	Holland & McCulloh Sts

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53530

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 53530

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 425 Robert Street ST. 14 WARD)

2-FULL NAME Jerome Sagel

(a) RESIDENCE No. 425 Robert Street ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) may 14 1891

7 AGE — Years: 9 Months: 11 Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Benj Sagel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Mary Agatsk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis
(Address) 1411 E Balto st

15 MAY 8-1921 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3rd 1918 to May 7th 1921 that I last saw h[illegible] alive on May 7th 1921 and that death occurred, on the date stated above, at 12:30p m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis
(Broken compensation)

(duration) 3 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M L Shidewell M. D.

19 (Address) 2328 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nelson Madison	5/8 1921
20 UNDERTAKER Jack Lewis 1411 E Balto st	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53531

CERTIFICATE OF DEATH.

79 D 53531

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2439 E Jefferson ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hagedorn.

(a) RESIDENCE. NO. 2439 E. Jefferson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emstein Hagedorn.

6 DATE OF BIRTH (month, day, and year) June 21, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	3	15.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John C. Hagedorn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Carii Randolf.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Wm. L. Hagedorn.
(Address) 101 S Clinton ST

15 FILED MAY 8-1921 SCHEER & KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1921, to May 6, 1921, that I last saw him alive on May 5, 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical

(Signed) C. A. Heuer M. D.

5/7. 1921 (Address) 240 E Balto, St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	May 9 1921
20 UNDERTAKER	ADDRESS
H Neemann.	320 Broad

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53532

CERTIFICATE OF DEATH.

170 D 53532

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 N. Caroline ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick C Spillman

(a) RESIDENCE. No. 716 N Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER George Spillman

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Lindenberger

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Henry Spillman
(Address) 716 N Caroline St

15 Filed MAY 8- 1921 19 ROBERT F. BRAUER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 7 - 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4th, 1921, to May 7th, 1921, that I last saw him alive on May 6th, 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) A Probability

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos H. A. Meyer, M. D.

5-7-1921 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 9th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

53533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 53533

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 675 Rivie St. ST. 17 WARD)

2-FULL NAME Lida Diggs

(a) RESIDENCE. No. 675 Riddle ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Augustus Diggs

6 DATE OF BIRTH (month, day, and year) Unknown, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at Home

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie Maddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Augustus Diggs (Address) 675 Riddle St.

15 Filed MAY 8-1921 ROBERT F. KRAMER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1921

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to May 5, 1921, that I last saw h[illegible] alive on May 5, 1921, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis and Nephritis

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John R Veasey M. D.

19 (Address) 723 George

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 7 1921

20 UNDERTAKER Samuel Hensley

ADDRESS 1711 Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history — Acute Nephritis - Acute Endocarditis.

Spec.—8-24-14—M. & T.—2000 Bks.

Pussey

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53534

CERTIFICATE OF DEATH.

29 D 53534

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 W. Fayette ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Henry E Pussey

(Residence in Baltimore: No. 1209 W Fayette St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, July (Month) 4 (Day), 1847 (Year)

7-AGE, 73 yrs. 9 mos. 3 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country). New York

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country). Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes A McDowell

(Address) 1209 W. Fayette

15-

Filed MAY 8- 1921 191.... FOREST A KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 21 1921, to May 7 1921, that I saw h[illegible] alive on May 6 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John A Evans M. D.

..... 191... (Address) 101 N Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Wilmington Del — DATE OF BURIAL, May. 11..., 1921.

20-UNDERTAKER, John W. Mitchell — ADDRESS 1201 W. Fayette

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53535

D 53535

CERTIFICATE OF DEATH.

REGISTERED No. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. # 524 N. Calhoun ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara B. McElderry

(a) RESIDENCE. No. 524 N. Calhoun ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. — mos. 21 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh McElderry

6 DATE OF BIRTH (month, day, and year) apr. 15-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm H. Bayzand

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Catharine Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

11 Informant Geo. W. Whiteside

(Address) 2925 Riggs Ave.

15 Filed MAY 8 1921 ROBERT F. BAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1921, to May 6, 1921, that I last saw h[illegible] alive on May 6, 1921, and that death occurred, on the date stated above, at 1125 P. M.

The CAUSE OF DEATH* was as follows:

Uremic poisoning

4 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

Indefinite

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What (est confirmed diagnosis) none

(Signed) A. B. Gould, M. D.

5/6 1921 (Address) 1405 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Mau	May 9— 1921

20 UNDERTAKER ADDRESS

John O. Mitchell 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 53536

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 451 St. Marys St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Mathews

(Residence in Baltimore: No. 451 St. Marys St. 42 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, April 5 ....., 1879
(Month) (Day) (Year)

7-AGE	If LESS than 1 day,
42 yrs. 1 mos. 1 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Mathews

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Eliza Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Luther Knight

(Address) 644 N. Paca St.

15-

Filed MAY 8-1921 101 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute nephritis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) mitral insufficiency

(Duration) ..... yrs. ..... mos. 2 1/2 ds.

(Signed) J. R. Hennessy M. D.
(Coroner.)

May 6. 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	May 8, 1921
20-UNDERTAKER John M. Johnson	ADDRESS 1234 Ethan St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53537

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53537

CERTIFICATE OF DEATH.

153

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1746 Bank St ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Walker

(Residence in Baltimore: No. 1521 Alicenna St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, April 27th, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Stefan F Walker.

11-BIRTHPLACE OF FATHER (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER Mary Wittig

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stefan F Walker

(Address) 1521 Alicenna St

15-

ROBERT J. KRAUTER

Filed MAY 8- 1921, 191.....

Registrar.

Serial

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of Colon

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) John Fuchs M. D.
(Coroner)

5-6, 1921 (Address) 1415 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	May 8th, 1921
20-UNDERTAKER Millard B Callender	ADDRESS Bank & Ann Sts.

Spec.—6-9-19—H. P. Co.—1009 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53538

CERTIFICATE OF DEATH.

679

REGISTERED NO. D 53538

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp. ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia McCullough

(a) RESIDENCE. NO. 2429 E. Fayette ST., WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo McCullough.

6 DATE OF BIRTH (month, day, and year) June 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63.	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work.

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm Stackpole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Frances Crail

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant: John Crawford (Address) 2429 E. Fayette st

15 Filed MAY 8-1921 19 ROBERT I. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1921, to May 8, 1921, that I last saw h Er alive on May 4, 1921, and that death occurred, on the date stated above, at 445 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Leilibur Stewart, M. D.

5/8, 1921 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel. DATE OF BURIAL May 10 1921

20 UNDERTAKER Wm Cook ADDRESS 502 E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

D 53539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 53539

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 340 E. 27th St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Katherine Hyland

(Residence in Baltimore: No. 340 East 27th St. St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 6th (Day), 1921 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 20 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Thomas Hyland

11-BIRTHPLACE OF FATHER (State or Country). U. S.

12-MAIDEN NAME OF MOTHER Mary Lucy Flaherty

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Thomas Hyland

(Address) 340 E. 27th St

15-

Filed MAY 8-1921, 191.... ROBERT A. CARTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 7th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6 1921, to May 7th 1921, that I saw her alive on May 6 1921, and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Cyanosis

Sec. marasmus

Still Birth 20 hrs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Culbertson M. D.

5/7, 1921 (Address) 1901 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Patricks Cemetery

DATE OF BURIAL, May 9, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spez.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53540

CERTIFICATE OF DEATH.

D 53540

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 916 Cleary St.: 21 Ward)

2-FULL NAME Jos. D Armiger

(a) RESIDENCE. No. 916 Cleary St., 21 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary T Armiger

6 DATE OF BIRTH (month, day, and year): Nov. 2-1841

7 AGE: Years 79 | Months 6 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Cody Punch Room

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Allentown Penn.

PARENTS

10 NAME OF FATHER: Louis Armiger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lehigh Co Penn

12 MAIDEN NAME OF MOTHER: Mary Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lehigh Co Penn

14 Informant: Mary Armiger
(Address) 916 Cleary

15 Filed MAY 8 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1921 to May 6 1921

that I last saw h[illegible] alive on May 6 1921

and that death occurred, on the date stated above, at 9:15 m.

The CAUSE OF DEATH* was as follows:

Chronic Dil of Heart 2 yrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia 30 ds.

(duration) yrs. mos. ds.

If Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? [illegible] Date of

Was there an autopsy? [illegible]

What test confirmed diagnosis? [illegible]

(Signed) H Schwenker M. D.

, 19 (Address) 1210 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet DATE OF BURIAL: May 9 1921

20 UNDERTAKER: William Cook ADDRESS: 5018 Work

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53541

CERTIFICATE OF DEATH.

64

D 53541

1-PLACE OF DEATH
CITY OF BALTIMORE (No. In front of 2924 Independence St WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME F. Margaret Ed

(Residence in Baltimore: No. 2901 Frisby St.: yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, May (Month) 5 (Day), 1849 (Year)

7-AGE 71 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Hancock Md

PARENTS.

10-NAME OF FATHER, Wm Murray

11-BIRTHPLACE OF FATHER (State or Country) Hancock Md

12-MAIDEN NAME OF MOTHER Hannah Wile

13-BIRTHPLACE OF MOTHER (State or Country) Hancock Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss E. Murray Cor

(Address) Ear Eye & Throat Hospital

15- Filed MAY 8 1921, 191.... Registrar.

ROBERT J. BRAUER
Assistant Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

May 7, 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Martinsburg W Va — DATE OF BURIAL, May 9, 1921

20-UNDERTAKER Wellmann Cook — ADDRESS 502 E North

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 53542

CERTIFICATE OF DEATH.

28 D 53542

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3127 W. North Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Loretta Schley

(a) RESIDENCE. No. 3124 W. North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 4. 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27 yrs	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John T. Schley

11 BIRTHPLACE OF FATHER (city or town) Frederick Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Tyrrell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Mrs Mary Schley
(Address) 3124 W. North Ave

15 Filed MAY 8 1921 ROBERT I. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6. 1921

17 I HEREBY CERTIFY, That I attended deceased from January 30, 1921, to May 6, 1921, that I last saw her alive on May 5, 1921, and that death occurred, on the date stated above, at 2 40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Mac O'Neill, M. D.

5/6. 1921 (Address) 108 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery	May 9 1921
20 UNDERTAKER	ADDRESS
Jos Foerderer's Son	217 S. Paca

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53543

CERTIFICATE OF DEATH.

21 D 53543

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 Sargeant St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara [illegible] Wagner

(a) RESIDENCE. No. 1222 Sargeant St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 6 mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14 1858

7 AGE: Years 63 Months 6 Days 21 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balt County Md

PARENTS

10 NAME OF FATHER John Betz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Christina Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Conrad F. Wagner
(Address) 1222 Sargeant St

15 FILED MAY 8 - 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1920, to May 5 1921, that I last saw him alive on May 5 1921, and that death occurred, on the date stated above, at 7 00 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A. Reed, M. D.

19 (Address) 1229 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stinesecombs Farms Cem	May 9 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2173 Bal

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 53544

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 Belvedere ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catarina Catalano -

(a) RESIDENCE. No. 416 Belvedere Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen Catalano

6 DATE OF BIRTH (month, day, and year) 2/1/1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vincent Fodotti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Compagna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Joseph Catalano 1511 Eastwood Ave

15 FILED MAY 8-1921 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6-1921

17 I HEREBY CERTIFY, That I attended deceased from 4-20 1921, to 5-6 1921, that I last saw her alive on 5-5 1921, and that death occurred, on the date stated above, at 1130 a. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis -

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis -

(Signed) J. J. Swarts, M. D.

, 19 (Address) 1057 Linden Ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	5/10/, 19
20 UNDERTAKER	ADDRESS
Geo J Ruth	1735 Hanford

Spec.—8-24-14—M. & T.—2000 Bks.

D 53545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53545

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1532 Mt Royal Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry O. Jones

(Residence in Baltimore: No. 1532 Mt Royal Ave St.; 78 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 3rd (Day), 1842 (Year)

7-AGE, 78 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cashier
(b) General nature of industry, business, or establishment in which employed (or employer): Wholesale clothing

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frederick H. Jones

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Henrietta Jones

(Address) 1532 Mt Royal Av

15- MAY 8-1921 Filed ..... 191.... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 6th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 31 1921, to May 6th 1921, that I saw him alive on May 6th 1921, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arterio sclerosis

(Duration) 4 yrs. — mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) — yrs. — mos. 3 ds.

(Signed) Steuart Bliss M. D.

May 6, 1921 (Address) 1227 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, May 9..., 1921.

20-UNDERTAKER Chas. E. Bonsack — ADDRESS 502 W. Madison Ave

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53546

CERTIFICATE OF DEATH.

1920 D 53546

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Shelter for Aged Colored Persons

CITY OF BALTIMORE: (No. 517 W. Biddle St. ST.: 10 WARD)

2-FULL NAME Susan Lewis

(a) RESIDENCE. No. 517 W. Biddle ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1st

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Matron of Home

(Address) 517 W. Biddle

15 Filed MAY 8- 1921 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th, 1921

17

I HEREBY CERTIFY, That I attended deceased from December 6th, 1920, to May 1st, 1921, that I last saw h er alive on May 12th, 1921, and that death occurred, on the date stated above, at 9 P ..m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (duration) 10 yrs. mos. ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Having a family Servant, Entering Shelter Exact date of birth

Did an operation precede death? And Cause of

Was there an autopsy? No General Weakness

What test confirmed diagnosis?

(Signed) A K Bond, M. D.

, 19 (Address) 3104 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Chap. St. Cem.	May 9 1921
20 UNDERTAKER	ADDRESS
Chas. E. Francis	502 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

47879

D 53547

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

+ 64

D 53547

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John E. Norman

(a) RESIDENCE. NO. 425 Hatton St Portsmouth Va. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mrs Virginia Norman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	4	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Meat Jobber

(b) General nature of industry, business, or establishment in which employed (or employer): merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Not Known.

11 BIRTHPLACE OF FATHER (city or town) North Carolina (State or country)

12 MAIDEN NAME OF MOTHER Clarissa Rodman

13 BIRTHPLACE OF MOTHER (city or town)? (State or country)

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAY 8 - 1921 ROBERT A. GRAUER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2nd, 1921, to May 8, 1921, that I last saw him alive on May 8, 1921, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage - FOR

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Further hemorrhage -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown -

Did an operation precede death? Yes Date of May 7 21

Was there an autopsy? Yes -

What test confirmed diagnosis? Operation -

(Signed) Mont R. Reid, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Portsmouth Va	May 8 1921
20 UNDERTAKER	ADDRESS
Joseph Owens	221 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the **DISEASE CAUSING DEATH (the primary affection** with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Exploratory craniotomy.
Left. Left decompression
Checking of hemorrhage.
No history of traumatism

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53548

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 64

D 53548

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1307 Webster St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Annie E. Etowski.

(Residence in Baltimore: No. 1307 Webster St.

47 St.: yrs., 5 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Married.

6-DATE OF BIRTH, November 29th. 1873., 1 .....
(Month) (Day) (Year)

7-AGE, 47 yrs. 5 mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Vincent Caprivia.

11-BIRTHPLACE OF FATHER (State or Country), Bohemia.

12-MAIDEN NAME OF MOTHER Annie Little.

13-BIRTHPLACE OF MOTHER (State or Country). Bohemia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Novak, (daughter)

(Address) 2712 Orleans St.

15 MAY 8-1921 ROBERT J. KRAUTH

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, au-
inquiry.....find that said deceased came to.....death
topsy or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:

.....
Cerebral Apoplexy.
.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed) Edward Reinhardt M. D.
(Coroner.)

May 8..., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL, May 9., 1921

20-UNDERTAKER Morgan J. Regan ADDRESS, 1422 Light St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

D 53549
1 PLACE OF DEATH

150 D 53549
REGISTERED No. C

CITY OF BALTIMORE (No. 1027 N Broadway St.: 7 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elenora Ruth Hunter

(Residence in Baltimore: No. 1027 N Broadway St.: ..... yrs. ..... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	single

6-DATE OF BIRTH May 5, 1921
(Month) (Day) (Year)

7-AGE ..... yrs. ..... mos. 2 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md

PARENTS

10-NAME OF FATHER Raymond F Hunter

11-BIRTHPLACE OF FATHER (State or country) Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Hunter

13-BIRTHPLACE OF MOTHER (State or country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. Hunter

(Address) 1027 N. Broadway

15 ROBERT F HAUTER

Filed MAY 9-1921 Burial Permit Issued REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 7, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5th, 1921, to May 7 1921; that I saw her alive on May 7, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth (7 months)
Partial closure of heart valve
(Blue baby)

(Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY) Congenital Debility

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) E. L. Peterson M. D.

May 8, 1921 (Address) 4223 York Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Lauden Park Cemetery

DATE OF BURIAL May 9, 1921

20-UNDERTAKER George J Ruth

ADDRESS 1735 Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53550

CERTIFICATE OF DEATH.

152 D 53550

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 E 26 ST.: 12 WARD)

2-FULL NAME Baby Hettinger

(a) RESIDENCE. No. 418 E 26 ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 12 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John Carl Hettinger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Tach

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant
(Address) Mrs. Hettinger 2631 N Calvert St

15 Filed MAY 9 1921 19 ROBERT F. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1921, to May 8, 1921, that I last saw h. alive on May 8, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. 12 hrs. mos. ds.

CONTRIBUTORY (Secondary) Premature

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys signs

(Signed) H. H. Schmidt M. D.

, 19 (Address) 2631 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Lutheran	May 9 1921

20 UNDERTAKER H. M. Cook 522 E North Ave ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53551

CERTIFICATE OF DEATH.

42 D 53551

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 17 W Barney ST.: 23 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia C Mebus

(a) RESIDENCE. NO. 17 W Barney ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. C. H. Mebus

6 DATE OF BIRTH (month, day, and year): June 20, 1859

7 AGE — Years: 61 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Dick

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Charles Adam

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Grimm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo C.H. Mebus

(Address) 17 W Barney St

15 Filed MAY 9—1921 ROBERT F. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 1919, to May 7, 1921, that I last saw h alive on May 6, 1921, and that death occurred, on the date stated above, at 8-30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. C. Comstock M. D.

May 7, 1921 (Address) 1674 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: May 9 1921

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53552

CERTIFICATE OF DEATH.

1921 D 53552

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 N. Fulton Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia Isabell Rueger

(a) RESIDENCE. NO. 1305 N Fulton Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Rueger

6 DATE OF BIRTH (month, day, and year) Jan. 23rd 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Josiah Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Addie Wales

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William Rueger
(Address) 1305 N. Fulton Ave

15 Filed ....., 19 .....
Registrar

MAY 9 1921 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 28 1921, to May 6, 1921, that I last saw her alive on May 6, 1921, and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic nephritis don't know (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) H. E. Knight, M. D.

, 19 (Address) 1002 N. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 9 1921

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53553

CERTIFICATE OF DEATH.

109

D 53553

1-PLACE OF DEATH University Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. 678 Mulberry St. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Moore

(a) RESIDENCE. No. 678 Mulberry St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 8th 1920.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	6 months		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) none.

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va Virginia

12 MAIDEN NAME OF MOTHER Elanor Tuffen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia Va.

14 Informant Eleanora Moore. (Address) 678 Mulberry st.

15 Filed MAY 9-1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1921, to May 7, 1921, that I last saw him alive on May 7, 1921, and that death occurred, on the date stated above, at 2 0 m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Intussusception

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 7, 1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Cyrus T. Howie, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 9th 21
20 UNDERTAKER	ADDRESS
Mrs Chas. B. Davis	21 Pine St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53554

CERTIFICATE OF DEATH.

42 D 53554

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 N. Fulton Ave. St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice D Dittman

(a) RESIDENCE. No. 1736 N Fulton Ave St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Dittman

6 DATE OF BIRTH (month, day, and year) Feb 28 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balti Co Md.

PARENTS

10 NAME OF FATHER John DeMoss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Tudor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant J. Harry Dittman (Address) 403 Springdale Ave

15 Filed MAY 9-1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 30, 1920, to May 5, 1921, that I last saw h[illegible] alive on May 5, 1921, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of vaginal fistula. Carcinomatous uterus removed 8 years ago.

(duration) 1½ yrs. mos. Abt

CONTRIBUTORY (Secondary) Hemorrhages from affected 5

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? Date of 8 years ago

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) Eudora Murray, M. D.

, 19 (Address) 1271 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	May 9 1921

20 UNDERTAKER Wm J Tickner Sons ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53555 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53555

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 207 Hare ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Wilkerson

(a) RESIDENCE. No. 207 Hare ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Edward Wilkerson

6 DATE OF BIRTH (month, day, and year) Cutmore

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co Md
(State or country)

PARENTS

10 NAME OF FATHER Sml Hawkins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Hawkins

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Edward Wilkerson
(Address) 207 Hare St

15 Filed MAY 9- 1921 ROBERT J. BRAUTIGAM Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1920, to May 7, 1921, that I last saw her alive on May 7, 1921, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. few mos. ds.

CONTRIBUTORY (Secondary) Acute Influenza

Rheumatism (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. A. Richardson M. D.

May 8 1921 (Address) 1120 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	May 9 1921
20 UNDERTAKER	ADDRESS
Samuel T. Hemsley	1781 Bridge

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53556

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-19

D 53556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10 N. Caroline ST.: 5 WARD)

2-FULL NAME John H Blackston.

(a) RESIDENCE. No. 10 N. Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs 11 mos. 6 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of un married

6 DATE OF BIRTH (month, day, and year) May 27 1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Blackston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maria Sunby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D C

14 Informant Maria Blackston

(Address) 10 N Caroline st

15 MAY 9-1921 ROBERT J KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 - 1921, to May 6, 1921, that I last saw him alive on May 5, 1921, and that death occurred, on the date stated above, at 10.15 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

&

Bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis & Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J G W Kennard M. D.

5-7. 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loucd	May 9 1921
20 UNDERTAKER John W Henderson	ADDRESS 1503 E. monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53557

HEALTH DEPARTMENT—CITY OF BALTIMORE

8-04 D 53557

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1145 N. Cleveland ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosaline V. Dietz.

(a) RESIDENCE. No. 1145 Cleveland ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER William P. Dietz

11 BIRTHPLACE OF FATHER (city or town) Louisville
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Mary M White

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant William P. Dietz
(Address) 1145 Cleveland ave

15 Filed MAY 9-1921 ROBERT I. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/21 19

17 I HEREBY CERTIFY, That I attended deceased from 5/5/21, 19, to 5/8/21, 19, that I last saw h. alive on 5/8/21, 19, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping Cy.

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Arbutus, Md.

Did an operation precede death? No. Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. H. Dennefe, M. D.

5/9, 19 21 (Address) 1302 N. Fonthill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Anns Annapolis	May 9 19 21
20 UNDERTAKER	ADDRESS
John J. Fields	1200 N. Fonthill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53558

CERTIFICATE OF DEATH.

D 53558

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto., Gen. Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank R. Leibig

(a) RESIDENCE. No. 435 Frederick ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augusta M

6 DATE OF BIRTH (month, day, and year): Dec. 27 1845

7 AGE — Years: 75 — Months: 4 — Days: 12 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Gram Coffee Works

(c) Name of employer: Curtis Bay and

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: M. Leibig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Augusta M Liebig (Address): 435 Fredrick St Brooklyn Md.

15 Filed MAY 9 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1921, to May 8, 1921, that I last saw h[illegible] alive on May 7 1921, and that death occurred, on the date stated above, at 1409 m.

The CAUSE OF DEATH* was as follows: Carcinoma of Pylorus of Stomach - 6 Mo

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M. D. Moore M. D.

, 19 (Address) So Balto. Gen Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: CEDAR HILL — DATE OF BURIAL: MAY 10 1921

20 UNDERTAKER: JOHN F. DENNY — ADDRESS: 715 LIGHT ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53559

CERTIFICATE OF DEATH.

D 53559

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2103 N. Fulton Ave St.; 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda M. Gill

(Residence in Baltimore: No. 2103 N Fulton Ave. St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 18th, 1855
(Month) (Day) (Year)

7-AGE, 66 yrs. 0 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Noah Eagle

11-BIRTHPLACE OF FATHER (State or Country), Delaware

12-MAIDEN NAME OF MOTHER, Rebecka Nichols

13-BIRTHPLACE OF MOTHER (State or Country), Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph H Gill

(Address) 2103 N Fulton Ave

15-

Filed MAY 9 1921, 191.... ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1921, to May 6 1921, that I saw h[illegible] alive on May 6 1921, and that death occurred, on the date stated above, at 5:[illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

Hemiplegia (Duration) yrs. 4 mos. ds.

(Signed) Chas A Rohde M. D.

May 9, 1921. (Address) 2052 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. — DATE OF BURIAL, 5 May, 1921.

20-UNDERTAKER Wm. Chas A. Rohde — ADDRESS 2052 Eutaw Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should date CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-3-19—H. P. Co.—1000 Bks.

Dinowitzer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53560

CERTIFICATE OF DEATH.

120 D 53560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Christian St. ST.: 20 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Dinowitzer

(a) RESIDENCE. NO. 2105 Christian ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernd

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Leby Biller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 E. Balto St

15 Filed MAY 9 1921 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17

I HEREBY CERTIFY, That I attended deceased from May 5 1921 to May 8 1921 that I last saw her alive on May 8 1921 and that death occurred, on the date stated above, at 3:00 m.

The CAUSE OF DEATH* was as follows:

Chr Interstitial Nephritis
Myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hemialgia

(Signed) Nathan Zuckerman M. D.

1921 (Address) 2151 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	May 9 1921

20 UNDERTAKER ADDRESS

Jack Lewis, 1411 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Roffen.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53561

D 53561

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Aged Home St.: 5 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rifka Roffen

(a) RESIDENCE. NO. Hebrew Aged Home St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 14 E Baltimore St

15 Filed MAY 9-1921 19 ROBERT I. KRAUTHER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to May 8 1921, that I last saw h[illegible] alive on May 8th 1921, and that death occurred, on the date stated above, at 5 30 p m.

The CAUSE OF DEATH* was as follows:

Gastric Cancer

(duration) yr. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D.

5/8, 1921 (Address) 210 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Sterling Run	May 9 1921

20 UNDERTAKER Jack Lewis ADDRESS 14 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 53562

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 W. Preston ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Sales.

(a) RESIDENCE. No. 223 W Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Black	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm Baltazzi

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Miss

PARENTS

10 NAME OF FATHER Thos Sales

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss

12 MAIDEN NAME OF MOTHER Anna Herring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Miss

14 Informant Mrs R A Elliott
(Address) 1725 Ashland ave

15 Filed MAY 9-1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb-4, 1921, to May 7, 1921, that I last saw h. alive on May 7, 1921, and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis. (a)

(duration) since Feb. 4-1921 yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Coma

(Signed) W R Jonah, M. D.

5-9-1921 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Summit Station Miss.	May 10th 1921
20 UNDERTAKER Mrs R-A. Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. F. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1476 53563 — 92D 53563

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: — WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Stewart

(a) RESIDENCE. NO. 111 S Durham St WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Zena Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAY 9 - 1921 . 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 - 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21 . 1921 . May 7 . 1921 .
that I last saw her alive on May 7 . 1921 .
and that death occurred, on the date stated above, at 4 05 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)
Empyema

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 111 S Durham St

Did an operation precede death? Yes Date of Apr 22 21

Was there an autopsy? no.

What test confirmed diagnosis? Thoracentesis

(Signed) H P Shellabear , M. D.

5-7-21 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 10 19 21
20 UNDERTAKER	ADDRESS
Wendel Dippelsdorf	37 S. Conn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53564

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 53564

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Briggs

(a) RESIDENCE. No. 1703 Fulton Ave ST. WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) Richmond
(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mrs. Wm Jacobs.
(Address) Columbus Ohio.

15 Filed MAY 9 1921 19 ROBERT E. LEE OTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 7, 1921, that I last saw him alive on May 7, 1921, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laudon Park.	May 9th 1921
20 UNDERTAKER	ADDRESS
Leo. G. Cook	North Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53565

CERTIFICATE OF DEATH.

151 D 53565

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Cumberland ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Sturm

(a) RESIDENCE. No. 707 Cumberland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 21, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Alphonse Sturm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Irene Bartell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Alphonse Sturm
(Address) 707 Cumberland St

15 Filed MAY 9 - 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1921, to May 8th, 1921, that I last saw him alive on May 7th, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Prematurely & lack of development (Ileo vii) 7 mo Fetus

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Malnutrition & Vomiting.

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Smith, M. D.

5/8, 1921 (Address) 1605 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	May 9 1921
20 UNDERTAKER	ADDRESS
Harry W. Ehlen	1948 W. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53566

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital St.; 6 Ward)

REGISTERED NO. 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Nelson

(a) RESIDENCE. No. 16 Bradford St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion E. Nelson

6 DATE OF BIRTH (month, day, and year) Aug 26-50

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Marian E. Nelson

(Address) 16 N. Bradford St

15 Filed MAY 9-1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/ 1921

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1921, to May 8, 1921, that I last saw h[illegible] alive on May 8th, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) Chas. E. Doherty M. D.

, 19 (Address) S. E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	May 10, 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2066 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53567

CERTIFICATE OF DEATH.

64 D 53567

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Penn ST.; 4th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Wilson

(a) RESIDENCE. No. 19 Penn ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Apr. 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32 about			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Alexander Wilson

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Hannah Annis Boyd

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant George W. Lair
(Address) 19 Penn

15 Filed MAY 9-1921 19 EMMET F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1921, to May 7, 1921, that I last saw her alive on May 6, 1921, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical Symptoms

(Signed) C. A. Horan, M. D.

19 21 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	5/10/21
20 UNDERTAKER	ADDRESS
John A Owens	538 Dolphin St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Frederick R. Bye.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 53568

D 53568

CERTIFICATE OF DEATH.

107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 St Paul ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Capt. Frederick R Bye

(a) RESIDENCE. NO. 2108 St Paul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Livery 086

(b) General nature of industry, business, or establishment in which employed (or employer): Driver

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Chester Co Pa

PARENTS

10 NAME OF FATHER: Thomas Bye

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Sarah Woolen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Edward R Bye

(Address) 400 Linden Ave.

15 MAY 9-1921 ROWE & FRAUTEN Undertakers Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1921, to May 7, 1921, that I last saw him alive on May 7, 1921, and that death occurred, on the date stated above, at 1 30 A m.

The CAUSE OF DEATH* was as follows:

Chr. Gastritis and Gastric Ulcer

has had frequent exacerbations

for some years, but for past few

months much better (duration) 3 yrs. about mos. ds.

CONTRIBUTORY (Secondary) Cardiac Syncope

(duration) yrs. mos. 3 days ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? only by symptoms & sign

(Signed) Robert W. Hoffman, M. D.

May 9 1921 (Address) No 1016 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 9 1921
20 UNDERTAKER: Rowe & Frauten Inc	ADDRESS: 14 & 24 Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53569

HEALTH DEPARTMENT—CITY OF BALTIMORE

150 ✓ D 53569

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1922 Lemmon St.: 20 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas H. Stolzenbach

(Residence in Baltimore: No. 1922 Lemmon St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May 7, 1921 (Month) (Day) (Year)

7-AGE, ...yrs....mos. 2 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Conrad Stolzenbach

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Lillian Kay

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conrad Stolzenbach

(Address) 1922 Lemmon St

15- MAY 9-1921 ROBERT J. KRAUTER

Filed ..... 191.. Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 7, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paranoia Ovale Dementia Praecox

(Duration) ....yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M. Fenton M. D. (Coroner.)

May 7, 1921 (Address) 700 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, May 9, 1921

20-UNDERTAKER Geo. L. Schwab & Bro — ADDRESS 2101 Eutaw Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53570

D 53570

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1222 N. Gay ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Gertrude Maurer

(a) RESIDENCE. No. 1222 N. Gay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	W	married

5a If married, widowed, or divorced WIFE of John Elmer Maurer

6 DATE OF BIRTH (month, day, and year) may 8-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hw.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Saml R. Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baton Mass.

12 MAIDEN NAME OF MOTHER Anna Cantlet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Emma Pittroff

(Address) 1222 N. Gay St

15 Filed MAY 9 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 8, 1921, to May 7, 1921, that I last saw h[illegible] alive on May 7, 1921, and that death occurred, on the date stated above, at 10:29 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary & Physical

(Signed) A. G. Horsnail, M. D.

6/8, 1921 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 10 1921
20 UNDERTAKER Geo Mosser	ADDRESS 1442 N Gay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53571 — 6th 53571

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore and Payson Sts.

CITY OF BALTIMORE: (No. German Aged Home ST.: 70 WARD)

2-FULL NAME Mary E. Brendel

(a) RESIDENCE. No. German Aged Home ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 30 1850

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	3	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work (Retired) School Teacher
(b) General nature of Industry, business, or establishment in which employed (or employer) 668
(c) Name of employer

9 BIRTHPLACE (city or town) Middletown
(State or country) Md.

PARENTS

10 NAME OF FATHER H. G. Brendel

11 BIRTHPLACE OF FATHER (city or town) Hagerstown
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Feete

13 BIRTHPLACE OF MOTHER (city or town) Middletown
(State or country) Md.

14 Informant Records German Aged Home
Address Balto. and Payson Sts.

15 Filed MAY 9-1921 19 [illegible]

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25th, 1921, to May 8th, 1921, that I last saw h.. alive on May 7th, 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
10 days.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Sclerosis
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) John A. Wyatt, M. D.

, 19 (Address) 1873 W. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md.	May 10 19 21
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W. Balto St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53572

CERTIFICATE OF DEATH.

159 D 53572

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1532 Hollins st ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augustus A. Conneleman

(Residence in Baltimore: No. 1532 Hollins st St.; 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Sept (Month) 14 (Day), 1866 (Year)

7-AGE, 54 yrs. 7 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Geo Conneleman

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Theresa Virginia Berry

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Conneleman

(Address) 1532 Hollins st

15- MAY 9-1921 ROBERT F. KRAUTER

Filed....., 191.... Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 6 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said.....(~~Inquest, autopsy~~ or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Bullet wound in left chest fired from a pistol in the hands of

(Duration) ..... yrs. a few mins mos. ds.

CONTRIBUTORY (Secondary) Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. K. Gorman M. D. (Coroner.)

5-7, 1921. (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Co DATE OF BURIAL, May 9th, 1921

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 W Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53573 40 D 53573

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 S. 4th ST.: 76 WARD)

2-FULL NAME John Mackessy

(a) RESIDENCE. No. 624 S. 4th ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rose Mackessy.

6 DATE OF BIRTH (month, day, and year) Nov. 13-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	5	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward Mackessy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mahon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John Mackessy Jr.
(Address) 809 S. Fouth St

15 Filed MAY 9-1921 ROBERT P. KRAUSE Registrar

Burial Permit Obtd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1921, to May 6, 1921, that I last saw h[illegible] alive on May 6, 1921, and that death occurred, on the date stated above at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm M. Carey, M. D.

May 8, 1921 (Address) 839 S. Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Cem.	May 10 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 W Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53574

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 ✓ D 53574

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Fait Ave ST.: 76 WARD)

2-FULL NAME Miriam S. Limmer

(a) RESIDENCE. No. 3710 Fait Ave ST., 76 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 13 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER August C. Limmer

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Bamisch

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant August C. Limmer
(Address) 3710 Fait Ave

15 Filed MAY 9 - 1921 ROBERT J. KRAUTER Registrar
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to May 8, 1921, that I last saw h.. alive on May 6, 1921, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. 1 mos. 23 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 1 mos. 23 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M J McAvoy, M. D.

(Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	May 9th 1921
20 UNDERTAKER Lilly & Gudefinder	ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53575

CERTIFICATE OF DEATH.

91 D 53575

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 S Chaces ST. 23 WARD)

2-FULL NAME Maggie Neill

(a) RESIDENCE. NO. 1904 S Chaces ST. 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Augt 7 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant James Neill
(Address) 1904 S Chaces St

15 Filed MAY 9 1924 19.... [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1924

17 I HEREBY CERTIFY, That I attended deceased from May 4 1924, to May 7 1924, that I last saw h[illegible] alive on May 7 1924, and that death occurred, on the date stated above, at 4-40 Am.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. C. Campbell M. D.

1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	5/9/24
20 UNDERTAKER	ADDRESS
Margaret V. Flynn	1417 Light St.

INSTRUCTIONS TO PHYSICIANS AND UNDERTAKERS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53576

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53576

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 S Kenwood Ave ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wiegand

(a) RESIDENCE. NO. 1023 S Kenwood Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Henry Wiegand

6 DATE OF BIRTH (month, day, and year) Nov 6, 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Valentine Gebeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Gros

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Wiegand

(Address) 1023 S. Kenwood ave

15 Filed MAY 9-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1921 to May 6, 1921, that I last saw h 4 alive on May 6, 1921 and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases (Genital)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Leo Kaminsky, M. D.

5/7, 1921 (Address) 3035 O'donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	May 10 1921
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53577

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53577

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1703 Moreland St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerene. Elizabeth Schuster

(a) RESIDENCE. No. 1703 Moreland St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	12	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Altenburg Germany.

PARENTS

10 NAME OF FATHER Frederick Barchers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oldenburg Germany

12 MAIDEN NAME OF MOTHER Elske Gelden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Richard Schuster
(Address) 1703 Moreland Ave

15 Filed MAY 9-1921 Robert P. Harrison, Registrar
Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2. 1921. to May 7. 1921.

that I last saw h.. alive on May 7. 1921.

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis 4 or 5 yrs.

Chronic Myocarditis.

Bronchio Pulmonary (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Oldenburg M. D.

5/10/21 (Address) 2757 Wyndotte Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorrain Cemetery	May 11 1921
20 UNDERTAKER George J Smith	ADDRESS 1000 Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53578 HEALTH DEPARTMENT--CITY OF BALTIMORE ✓ D 53578

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. M. E. Home for Aged St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conway Roberson

(Residence in Baltimore: No. Sutton Ave & Franklin St.; 52 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M.

4-COLOR OR RACE: W.

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: June (Month), (Day), 1844 (Year)

7-AGE: 76 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Va

PARENTS

10-NAME OF FATHER: Nathaniel Roberson

11-BIRTHPLACE OF FATHER (State or country): England.

12-MAIDEN NAME OF MOTHER: Jakie Vaughn

13-BIRTHPLACE OF MOTHER (State or country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Etta Cuddy
Supt. M. E. Home for Aged
(Address)

15. Robert P. Harrison, , 191
Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 8 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8th, 1921, to, May 8th 1921, that I saw h[illegible] alive on May 7, 1921, and that death occurred, on the date stated above, at 8:30 a.m.
The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Arteris Sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) O. N. Shoaff M. D.

May 9, 1921. (Address) 1817 N Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: May 10, 1921

20-UNDERTAKER: George J. Smith — ADDRESS: 1825 W Fayette St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAKING THIS A PERMANENT RECORD

Y9-1921

Spec.—6-9-19—H. P. Co.—1000 Rks.

D 53579

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53579

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Volunteers of American Hospital WARD 4

CITY OF BALTIMORE: (NO. 418 W. Lexington ST.:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Laura D. Smith Annapolis, Md

(a) RESIDENCE. NO. 74 Charles ST., WARD. Annapolis Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Smith

6 DATE OF BIRTH (month, day, and year) Dec 10-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co Md

PARENTS

10 NAME OF FATHER James O. Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Port Charles Co Md

12 MAIDEN NAME OF MOTHER Ann Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Port Charles Co Md

14 Informant (Address) Frank O. Smith 74 Charles St Annapolis Md

15 Filed MAY 9-1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8-1921

17 I HEREBY CERTIFY, That I attended deceased from 11-26, 1921, to 5-7, 1921, that I last saw h[illegible] alive on 5-7, 1921, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows: Following the operation

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma Large Bowel

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 74 Chas. St Anna Polis Md

Did an operation precede death? Yes Date of 5-5-21.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Fairwell M. D.

5-8, 1921 (Address) 418 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery Annapolis Md	5/11-1921
20 UNDERTAKER B L Hopkins	ADDRESS Annapolis Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state nation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53580 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53580

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., 16 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Nutt

(a) RESIDENCE. No. 1504 Mosher St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Howard Monroe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Nutt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mary Nutt (mother) 1504 Mosher St

15 Filed Robert P. Harrison, Registrar

MAY 9-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1921, to May 7, 1921, that I last saw h'm alive on May 7, 1921, and that death occurred, on the date stated above, at 6 40 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth (32 Weeks fetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

5-7, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS MAY 9 - 1921

Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53581

D 53581

151

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Melville Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dolly Florence Bradley

(Residence in Baltimore: No. 604 Melville Ave St.; - yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 7 (Day), 1921 (Year)

7-AGE, - yrs. - mos. - ds.

If LESS than 1 day, 1 hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Thomas L Bradley

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Edith Bryan

13-BIRTHPLACE OF MOTHER (State or Country), Phila Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas L Bradley

(Address) 604 Melville Ave

15-

Filed ... 191... Robert P. Harrison, Registrar.

MAY 9-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 7 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 7 1921, to May 7 1921, that I saw her alive on May 7 1921, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) E M Duncan M. D.

May 7, 1921 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, St Peters Cem

DATE OF BURIAL, May 9, 1921

20-UNDERTAKER Martin Fahey & Sons

ADDRESS 1827 N North Ave

WRITE PLAINLY.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53582

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53582

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1423 Columbia Ave (St.) 21 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John McMitchell

(a) RESIDENCE. No. 1423 Columbia Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Martha A. Mitchell

6 DATE OF BIRTH (month, day, and year) Feb 16th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Revere Rubber Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John R. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Bratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Martha A. Mitchell

(Address) 1423 Columbia Ave

Filed MAY 9 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 19 21, to May 7, 19 21, that I last saw h me alive on May 7, 19 21, and that death occurred, on the date stated above, at 5.15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Harry Bond, M. D.

(Address) 604 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	May 10th 1921
20 UNDERTAKER	ADDRESS 1034
E. Schloman's Son	Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53583

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Carlton ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Smith

(a) RESIDENCE. No. 219 Carlton ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) May 1st 1897

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co Va

PARENTS

10 NAME OF FATHER Griffin Nutt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co Va

12 MAIDEN NAME OF MOTHER Maria Watty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co Va

14 Informant Anthony Smith

(Address) 219 N. Carlton st

15 [illegible] 19

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MAY 9-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1921

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1921, to May 7, 1921, that I last saw h.r alive on May 7, 1921, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Frank Thompson, M. D.

May 9, 1921 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 10th 1921
20 UNDERTAKER	ADDRESS
A Jones	207 S Stricker

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 53584

147898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 53584

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 22 WARD)

2-FULL NAME Henry Craft.

(a) RESIDENCE. No. 703 S. Green ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hilton & Sarah Craft.

6 DATE OF BIRTH (month, day, and year) March 22 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Hilton Craft.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Sarah Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital. (Address) Beeade

15 MAY 10 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1921, to May 8, 1921, that I last saw her alive on May 8, 1921, and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) — yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann

(Signed) W. Bauman, M. D.

5-9, 1921 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct.	May 10 1921
20 UNDERTAKER	ADDRESS
N. W. F. Brown & Son	108 W. Monty

MAIL—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 67

D 53585

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Corp'l G. N. Wink

(Residence in Baltimore: No. 711 Carroll St.

St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	single

6-DATE OF BIRTH, Dec. 16, 1916
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
4 yrs. 4 mos. 23 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... Child

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Wink

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Edith Shook.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Wink

(Address) 711 Carroll St.

15-

Filed MAY 10 1921 191.... ROBERT J. KRAUTER Registrar.

Burial Permit Used

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH May 8, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st, 2nd & 3rd degree burns of body. (Accident) Conflagration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 3½ hrs

(Duration) yrs. mos. ds.

(Signed) J. C. D. Hennessy M. D.
(Coroner.)

May 9, 1921 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? 711 Carroll St.

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Randallstown	May 10 1921

20-UNDERTAKER Chenoweth & Son ADDRESS Chestnut Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Hurp.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53586

CERTIFICATE OF DEATH.

28 D 53586

REGISTERED NO.....

1-PLACE OF DEATH Hakesley.

CITY OF BALTIMORE: (No. 1615 Hackley Place ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella A. Harp.

(a) RESIDENCE. No. 1615 Hackley Pl. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Charles Harp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Susan Harp (Address) 1615 Hackley Place

15 Filed MAY 10 1921 19 [illegible] Registrar

Burial [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1919, to May 8, 1921, that I last saw her alive on May 8th, 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Daniel Miller, M. D.

19 (Address) 1506 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's H.	May 11 21

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Fait Rd

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53587

CERTIFICATE OF DEATH.

28 D 53587

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 S Duncan ST.; WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josefine Jozefowicz.

(a) RESIDENCE. No. 510 S Duncan WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Mar 5. 1899.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Albert Rybicki.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Mary Jankowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: John Josefowicz. (Address): 510 S Duncan St

15 Filed MAY 10 1921 19 ROBERT J. KRAUTER Registrar

Burial permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1. 21. to May 8. 1921.

that I last saw h-- alive on Mar 8. 1921.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Does not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam

(Signed) J. Kirk Insley, M. D.

19 (Address) 2938 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus.

DATE OF BURIAL: May 11 1921.

20 UNDERTAKER: M. Sadowski

ADDRESS: 705 S. Ann

MARK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53588

CERTIFICATE OF DEATH.

79 D 53588

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Greenmount Av. ST.; 17 WARD) REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hedwig Luba.

(Residence in Baltimore: No. 2020 Greenmount Ave St.; 32 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E B. Hentwerk

(Address) 2020 Greenmount Ave

15- Filed MAY 10 1921 1921 ROBERT P. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 20, 1921, to May 8 1921, that I saw her alive on May 8, 1921, and that death occurred, on the date stated above, at 9.59 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Ill for 25 years)

(Duration) yrs. 24 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hugh Forsythe M. D.

May 9, 1921. (Address) 424 E North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	May 11, 1921
20-UNDERTAKER	ADDRESS
M. J. Sadowski	705 S. Ann St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53589

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53589

79-091

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 S. Regester ST.; 2 WARD)

2-FULL NAME Mary Szczukowska

(a) RESIDENCE. NO. 707 S. Regester ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., If of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Szczukowski.

6 DATE OF BIRTH (month, day, and year) Sep. 8-1865.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Antoni Studzynski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Agnes —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Max Szczukowski.
(Address) 707 S. Regester St.

15 Filed MAY 10 1921 ROBERT F. BAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-9-1921

17 I HEREBY CERTIFY, That I attended deceased from April-7-, 1921, to May-9-, 1921, that I last saw her alive on May-8-, 1921, and that death occurred, on the date stated above, at 8. a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) — yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William H. Johnson, M. D.

5/9. 1921 (Address) 2016 Guilford ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Crm.	May 12" 1921.

20 UNDERTAKER M. F. Sadowski. ADDRESS 905 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53590

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53590

92

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 942 Greenmount ST.; 10 WARD)

2-FULL NAME Cecilia Jaffe

(a) RESIDENCE. No. 942 Greenmount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? 32 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Jaffe

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hessel Hesselberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 E Balto St

15 Filed MAY 10 1921 19 ... Registrar

Burial Permit 01888

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921 to May 8 1921 that I last saw her alive on May 8 1921 and that death occurred, on the date stated above, at 10.30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Peltetman M. D.

5/9 1921 (Address) 829 Hamilton Terr.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Henry Rus	5/10 1921

20 UNDERTAKER Jack Lewis 1411 E Balto St — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53591 ✓ D 53591

43

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. Lafayette & Johns ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Esther Harber

(Residence in Baltimore: No. 904 Pennsylvania Ave St.; 40 yrs., 1 mos. ds.)

WRITE PLAINLY, WITH ONFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
White	Female	Married

6-DATE OF BIRTH, Sept 21st (Month) (Day), 1876 (Year)

7-AGE, 44 yrs. 7 mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Samuel Black

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Mollie Kruger

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15- MAY 10 1921 Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 3 1921, to May 9 1921, that I saw her alive on May 9 1921, and that death occurred, on the date stated above, at 10.45 A.m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma of Uterus - Operation

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

..... (Duration) 1 yrs. 2 mos. ..... ds.

(Signed) Frank DeWaltham Stone M. D.

May 9, 1921. (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 1 mos. 17 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Beth Shalom	May 10, 1921

20-UNDERTAKER Jack Lewis 1411 E Balto St

ADDRESS

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 53592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53592

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 S. Monroe St. 20 WARD)

2-FULL NAME Fannie Passen

(a) RESIDENCE. No. 412 S. Monroe St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon Passen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1[illegible] E. Balt st

15 Filed MAY 1 0 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept 15th 1920 to May 9 1921

that I last saw her alive on May 9th 1921

and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 8 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Chodenth, M. D.

, 19 (Address) 2328 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom	5/10 1921
20 UNDERTAKER	ADDRESS
Jack Lauson	710 E Balt st

INSTRUCTIONS. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53593

D 53593

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 827 N Linwood ave ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine M. Hart

(a) RESIDENCE. NO. 827 N Linwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nimrod F Hart

6 DATE OF BIRTH (month, day, and year) April 10. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	—	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joshua Pedrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Henry Schneider

(Address) 827 N Linwood ave

15 Filed MAY 10 1921 ROBERT J KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1921

17

I HEREBY CERTIFY, That I attended deceased from Nov 25 1919, to May 6, 1921, that I last saw h[illegible] alive on May 6 1921, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia Hypostatic

(duration) yrs. 6 mos. 1 ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) J W Schneider, M. D.

5-9, 1921 (Address) 3307 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 10 1921
20 UNDERTAKER	ADDRESS
J Henry & Co	210 Eutaw

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53594

HEALTH DEPARTMENT—CITY OF BALTIMORE

91

D 53594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S. Wolfe ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Elmer Stark.

(a) RESIDENCE. No. 414 S. Wolfe ST., 2 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——— Child

6 DATE OF BIRTH (month, day, and year) May 19 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER William T. Starke

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Martin

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Carrie Starke Mother
(Address) 414 S. Wolfe St

15 FILED MAY 10 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1921, to ....., 19..., that I last saw him alive on May 7th, 1921, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Singewald M. D.

5/9, 1921 (Address) 5 N. Washington Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	May 10th 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53595

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 53595

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 839 Hamilton Terrace ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah M. Lytle

(Residence in Baltimore: No. 839 Hamilton Terrace St.: 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, March 25, 1838
(Month) (Day) (Year)

7-AGE, 83 yrs. 1 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... gdd

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, James J Taylor

11-BIRTHPLACE OF FATHER (State or Country), N.J.

12-MAIDEN NAME OF MOTHER Ann Higgins

13-BIRTHPLACE OF MOTHER (State or Country), N.J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Margaret Lytle

(Address) 839 Hamilton

15- Filed MAY 10 1921, 191.....

ROBERT J KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 7, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

14 hrs (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. C. J. Kenworthy M. D.
(Coroner.)

May 9, 1921 (Address) 2802 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Abingdon Md

DATE OF BURIAL, May 10 1921

20-UNDERTAKER W M Rowson

ADDRESS 230 N Greene

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53596

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109 D 53596

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Monument St ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B Le Compte

(Residence in Baltimore: No. 2926 Riggs ave St.; 79 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 30, 1842
(Month) (Day) (Year)

7-AGE, 79 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John T Le Compte

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Jo

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lamar R Le Compte

(Address) 2926 Riggs ave

15- MAY 10 1921 ROBERT J KRAUTER

Filed ....., 191.. Registrar. Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 7 1921, to May 8 1921, that I saw h[illegible] alive on May 8 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction due to
Strangulated hernia ent
Sigmoid flexure

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

May 9, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem

DATE OF BURIAL, May 11, 1921.

20-UNDERTAKER H M Routson

ADDRESS 2238 N Monroe

Arnetta

Spec. 6-9-19—H. P. Co.—1000 Bks.

1775/2
D 53597

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53597

112

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO Johns Hopkins Hospital ST.. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Arnetta

(a) RESIDENCE. NO. 730 Colvin St. Baltimore Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) 1/31/1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Vincent Arnetta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Calloroffeo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Johns Hopkins Hospital

15 Filed MAY 10 1921 ROBERT F. HAITER Registrar

Burial Permit Given

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should mation should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17

I HEREBY CERTIFY, That I attended deceased from April 13 , 1921 , to May 8 , 1921 .

that I last saw h alive on May 8 , 1921 .

and that death occurred, on the date stated above, at 11 P- m.

The CAUSE OF DEATH* was as follows:

Hydatid cysts. (Infected).

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Infection Jaundice.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of 5/1/21

Was there an autopsy? Yes.

What test confirmed diagnosis? Finding of hooklets.

(Signed) H H Lancefield , M. D.

5 9, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL 5/10/21

20 UNDERTAKER Geo J Ruth — ADDRESS 1735 Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53598

REGISTERED NO. 79 D 53598

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 N. Montford Ave. WARD 8)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie M. Sleicht

(a) RESIDENCE. NO. 1827 N. Montford Av WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Sleicht

6 DATE OF BIRTH (month, day, and year) Sept 29 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co. Md

PARENTS

10 NAME OF FATHER Henry S. Hart.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co. Md

12 MAIDEN NAME OF MOTHER Mia. Stayed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr James Sleicht

(Address) 1827 N. Montford Ave

15 Filed MAY 10 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to May 9 1924, that I last saw h[illegible] alive on May 8 1924, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. E. Chambers, M. D.

May 10 1924 (Address) 1301 N Pat Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shrewsbury Pa.	May 11th 1924
20 UNDERTAKER Henry Horst Son	ADDRESS 1301 E Eager St

MAY 10 1921 BOMBERGER KRAUTER Burial Permit Clerk

7-102

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53599

CERTIFICATE OF DEATH.

D 53599

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph's Hospital ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Fulan.

(a) RESIDENCE. NO. St Joseph Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if of foreign birth? 61 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	78	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Records of St Joseph's Hospital Caroline & Wolfman Sts.

15 Filed MAY 10 1921 19 ROBERT A KRAUTER Registrar Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/9/21

17 I HEREBY CERTIFY, That I attended deceased from 6/7/19, to 5/9/21, that I last saw h[illegible] alive on 5/9/21, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Chas C Donovan, M. D.

, 19 (Address) 8-E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	May 11 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53600

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53600

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3008 Mc Keys st ST.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Hazlett

(Residence in Baltimore: No. 3008 Mc Keys st St.; 54 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Don't Know, 1 (Month) (Day) (Year)

7-AGE, about 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Housework

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, James Keys.

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry E. Hazlett

(Address) 3008 Mc Keys st

15- ROBERT P. FOUTER

Filed MAY 1 01921 192... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 9th 1920, to May 9th 1921, that I saw h.r alive on May 6th 1921, and that death occurred, on the date stated above, at 4 45 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. A. Galwath M. D.

Jan 9th, 1921. (Address) 737 Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	April 11, 1921.
20-UNDERTAKER, William Cook	ADDRESS 502 W. Natl Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53601

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53601

40

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3232. Cedar Ave ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah. Emma Carmine

(a) RESIDENCE. No. 3232 Cedar av ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Robert K Carmine

6 DATE OF BIRTH (month, day, and year) Sept 3rd 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Barnitz Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Margaret L Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Robert K Carmine

(Address) 3232 Cedar ave

15 Filed MAY 10 1921 ROBERT F [illegible] Register

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1921, to May 8, 1921, that I last saw her alive on May 7, 1921, and that death occurred, on the date stated above, at 5-15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) [illegible] M. D.

6/8, 1921 (Address) 846 W 36 st 8V-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	May 11th 1921
20 UNDERTAKER	ADDRESS
George Schulling & Sons	1126 E Monument st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53602

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53602

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 N Gay ST.; 10 WARD)

2-FULL NAME John W. Smith

(a) RESIDENCE. No. 714 N. Gay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Ada V. Smith

6 DATE OF BIRTH (month, day, and year) Mar 22nd 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sewing Machine Mgr

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J. Walter Smith
(Address) White Hall Towson Road

15 Filed MAY 10 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1921, to May 10, 1921, that I last saw him alive on May 9, 1921, and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Sanderson M. D.

, 19 (Address) 1714 N. Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 13 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E. Monument St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53603

CERTIFICATE OF DEATH.

91 D 53603

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 McCulloh ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Smallwood.

(a) RESIDENCE. No. 1122 - McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Grace Taylor

(Address) 1611 Hollins

15 Filed MAY 10 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1921

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1921, to May 7, 1921, that I last saw her alive on May 6, 1921, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. C. Johnson, M. D.

May 10 1921 (Address) 211-8 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 10 1921
20 UNDERTAKER Samuel T. Chandler	ADDRESS 2 E. Baltimore

MAY 10 1921

Registrar

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53604

CERTIFICATE OF DEATH.

1920 D 53604

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S Chester ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Antkowiak

(a) RESIDENCE. NO. 523 S Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late John Antkowiak

6 DATE OF BIRTH (month, day, and year) Dec 25 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jacub Stachowiak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Mary Banach
(Address) 523 S Chester St

15 MAY 10 1921 Filed, 19 ROBERT A KEATING Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1921

17 I HEREBY CERTIFY, That I attended deceased from April 20 1921, to May 8 1921, that I last saw h[illegible] alive on May 7 1921, and that death occurred, on the date stated above, at 345 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Rt Hemiplegia)

(duration) yrs. 1 mos. 02 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 11 1921

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

R. F. [illegible] THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Zak.

D 53605

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

120 D 53605

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 S Patterson Park ave ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Zak

(a) RESIDENCE. No. 605 S Patterson Park ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Josephine Zak

6 DATE OF BIRTH (month, day, and year) Feb 28 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michal Grochowina (Address) 605 S Patterson Park ave

15 Filed MAY 10 1921 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1921, to May 9, 1921, that I last saw h— alive on May 9, 1921, and that death occurred, on the date stated above, at 1130 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Bright's disease

(duration) yrs. unknown mos.

18 Where was disease contracted if not at place of death? 605 S Patterson Park ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Frank Zak M. D.

May 9. 1921 (Address) 2431 Fleet

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	May 11 1921

20 UNDERTAKER John McWeber ADDRESS 1803 Bank

INFORMATION SHOULD BE WRITTEN WITH PEN AND INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53606

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 117 W. Montgomery St. St.: 22 79 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Goldsborough. (C)

(Residence in Baltimore: No. 117 W. Montgomery St.

54 ------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH, Do not know. (Month), 1 (Day), ... (Year)

7-AGE,	If LESS than 1 day.
58 yrs. ------- mos. ------- ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Horace H. Gray. (C)

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Margaret Boardley. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Margaret Haywood. (C) daughter.

(Address) 117 W. Montgomery St.

15-

Form ..... MAY 10 1921 191.....

Burial Permit ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Reinhardt M. D.
(Coroner.)

May 9..., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	May 11, 1921

20-UNDERTAKER	ADDRESS
J. H. Broun & Son	108 N. Monty St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53607

150 D 53607

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4726 Little North Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Marie Hehrs

(a) RESIDENCE. No. 4726 Little North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4 1919

7 AGE — Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. (Towson) Md.

PARENTS

10 NAME OF FATHER: John Wm Hehrs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Helena Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: John Wm Hehrs
(Address) 4726 Little North Ave

15 Filed MAY 10 1921 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1921, to May 10, 1921, that I last saw h[er] alive on May 9, 1921, and that death occurred, on the date stated above, at 3-30 A m.

The CAUSE OF DEATH* was as follows:

Debility
Pneumonia Double not Classed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Lair, M. D.

, 19 (Address) 12 E. 26th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Cem — DATE OF BURIAL: May 10 1921

20 UNDERTAKER: John Burns Sons — ADDRESS: Towson

N. B.—WHITE CARDS, etc., will be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully classified. Exact statement may be properly classified. Exact statement may be CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

Daniel B. Hatch

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53608

CERTIFICATE OF DEATH.

D 53608

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME D. B Hatch

(a) RESIDENCE. NO. Houston Texas ST., WARD. Houston Texas

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Ruth Hatch

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Miss

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Robert Brookeson

(Address) 17 S. Calhoun St

15 Filed ..... 19..... ROBERT A KRAUTER Registrar

MAY 10 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1921, to 5-9, 1921, that I last saw him alive on 5-9, 1921, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue involving gland of neck

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from Carotid artery (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-2-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Craig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Houston Texas	MAY 10 1921
20 UNDERTAKER Robert Brookeson	ADDRESS 17 S. CALHOUN ST

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(McIvor)

D 53609 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

91 D 53609

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 819 Sterling ST.: 10 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard McIvor

(Residence in Baltimore: No. 819 Sterling St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Mel	Col	Bach

6-DATE OF BIRTH, May 5, 1921
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 0 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Bernard McIvor

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Paige

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary McIvor

(Address) 819 Sterling

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

MAY 10 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea Enteritis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) H. K. Bowen M. D.
(Coroner)

5-10-, 1921. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, MAY 10 1921, 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Department of Health

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53610

D 53610

50-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Walker

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairyman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Herman Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed MAY 10 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1921

17 I HEREBY CERTIFY, That I attended deceased from November 11, 1920, to May 6, 1921.

that I last saw him alive on May 6, 1921.

and that death occurred, on the date stated above, at 4:30 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broaches - Pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory -

(Signed) F. A. Holden, M. D.

5/7/ 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	5/10 1921
20 UNDERTAKER	ADDRESS
Chas. P. Evans & Son	1100 W. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53611 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53611

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 629 S. Curley ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Keyser

(a) RESIDENCE. No. 629 S. Curley ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7- 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	-	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piano

(b) General nature of Industry, business, or establishment in which employed (or employer) Varnisher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Keyser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs. Ella House (Address) 629 S. Curley St

15 Filed MAY 1 0 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9- 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10 - 1921, to May 9 - 1921, that I last saw h~ alive on May 9- 1921, and that death occurred, on the date stated above, at 2300 m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) 340 Schroeder.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 12- 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. Nott

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53612

CERTIFICATE OF DEATH.

28 D 53612

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 4107 First ave ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman W. Fiennan

(Residence in Baltimore: No. 4107 First Ave St.; 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, April 22nd, 1908.
(Month) (Day) (Year)

7-AGE, 13 yrs. — mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Herman Fiennan

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Matilda Buck

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Fiennan

(Address) 4107 First ave

15-

Filed MAY 10 1921 Robert P. Garrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1920, to May 10 1921, that I saw him alive on May 9th 1921, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. W. Jones M. D.

May 10, 1921. (Address) 410 1st ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Schwarz Cemetery	May 12, 1921.
20-UNDERTAKER Wallace Cook	ADDRESS 502 E Wood St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIAN should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53613

CERTIFICATE OF DEATH.

29 D 53613

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2810 Halbrook ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry William Schattuck

(a) RESIDENCE. No. 2810 Halbrook St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Schattuck

6 DATE OF BIRTH (month, day, and year) May 1 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Instruments

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm Schattuck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Schattuck (Address) 2810 Halbrook

15 Filed Robert P. Harrison, Registrar

MAY 10 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8th 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19th 1921, to May 8th 1921, that I last saw him alive on May 8th 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. E. Jones, M. D.

5/15, 1921 (Address) 720 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 11 1921
20 UNDERTAKER	ADDRESS
W. F. Turner & Son	Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53614 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53614

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Aisquith St.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Yost

(Residence in Baltimore: No. 1428 Aisquith St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, (MARRIED), WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Jan (Month) 29 (Day), 1834 (Year)

7-AGE, 87 yrs. 3 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired Coppersmith
(b) General nature of industry, business, or establishment in which employed (or employer). Molasses Co

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Yost

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Yost

(Address) 1428 Aisquith St.

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

MAY 10 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 9 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 29 1921, to May 8 1921, that I saw him alive on May 8 1921, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Uremia

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George McGlennon M. D.

May 10, 1921 (Address) 20 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western — DATE OF BURIAL, May 12, 1921

20-UNDERTAKER Geo W Little — ADDRESS 2708 Edmondson Ave

Spec.—8-24-14—M. & T.—2000 Bks.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53615

CERTIFICATE OF DEATH.

29

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 221 S. Chester St. St.: 1 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertruda Tomalski

(Residence in Baltimore: No. 221 S. Chester St. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	

6-DATE OF BIRTH, May 26/1911, 1
(Month) (Day) (Year)

7-AGE, 9 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ------
(b) General nature of industry, business, or establishment in which employed (or employer) ------

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Thomas Tomalski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Magdalene Twandowisz

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Tomalski

(Address) 221 S. Chester St.

15-Filed MAY 11 1921 ROBERT J KRAUTER Registrar. Burial Permit (Clerk).

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9/21, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cause; Valvular Heart Disease

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner)

5/10, 1921 (Address) 1800 E Rhode

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary — DATE OF BURIAL, May 11 1921

20-UNDERTAKER Hall Sons & McCaskey — ADDRESS Balto

Spec.—8-24-14—M. & T.—2000 Bks.

James E. Williams

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53616

CERTIFICATE OF DEATH.

119 D 53616

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Stirling St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Williams

(Residence in Baltimore: No. 802 Stirling St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June ....., 1 .....
(Month) (Day) (Year)

7-AGE, 73 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Laborer

9-BIRTHPLACE, (State or Country). born in Baltimore

PARENTS.

10-NAME OF FATHER, Lebo Williams

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Payne

(Address) 802 Sterling St

15- ROBERT P. CRAWFORD

Filed MAY 11 1921 Racial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9th, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1921, to May 8th 1921, that I saw h alive on May 8 191..., and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John O Stewart M. D.

5-10, 1921 (Address) 704 W Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, National Cem — DATE OF BURIAL, May 11..., 1921

20-UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53617

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53617

CERTIFICATE OF DEATH.

143

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 W. North Av. ST.: 15 WARD)

2-FULL NAME Wilbur I. Freeburger

(a) RESIDENCE. NO. 1701 W North Av ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Freeburger

6 DATE OF BIRTH (month, day, and year) July 4th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ins. Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Soliciting Ins.

(c) Name of employer Metropolitan Ins Co. Balto. Md

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Isaac Freeburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Jennie Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Anna Freeburger

(Address) 1701 W North Av.

MAY 11 1921

ROBERT J. KRAUTZ Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 31st 1921, to May 10th 1921, that I last saw h[illegible] alive on May 10th 1921, and that death occurred, on the date stated above, at 7.20 A m.

The CAUSE OF DEATH* was as follows:

Pernicious Carbuncle on neck, in process of healing, degeneration changes in heart muscles

(duration) yrs. mos. 41 ds.

CONTRIBUTORY (Secondary) Failing Heart

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Several

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) E. L. Smith, M. D.

May 10 1921 (Address) 1606 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 14 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E Nash

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53618

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53618

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital ST.; 7 WARD)

REGISTERED No. C 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Brown

(Residence in Baltimore: No. Spruce Pois' St.; yrs., mos. 1 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	Col.	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
10 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): School Girl

9-BIRTHPLACE, (State or Country) Sparrow Pourt

PARENTS.

10-NAME OF FATHER, Fenton Brown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Ever Talon

13-BIRTHPLACE OF MOTHER (State or Country), in Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G Fenton Brown

(Address) Sparrow Pourt

15-Filed MAY 11 1921 ROBERT J. KRAFFT Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10 (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns whole person with boy flame

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner)

May 7 1921 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Sparrows Pt

Former or usual residence Sparrows Pt

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Remington Va	May 11, 1921

20-UNDERTAKER Mrs R A Elliott ADDRESS 1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53619

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH Robert Garrett Hospital

CITY OF BALTIMORE: (No. 27 N. Carey St ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Earle Through

(a) RESIDENCE. No. 3042 Abell Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or estshlishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Earle Through

11 BIRTHPLACE OF FATHER (city or town) York, Pa
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Stubbs

13 BIRTHPLACE OF MOTHER (city or town) New York City
(State or country)

14 Informant Mrs. Earle Through
(Address) 3042 Abell Ave

15 Filed MAY 1 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to May 9, 1921, that I last saw him alive on May 9, 1921, and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 2 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 2 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D.C. Wharton Smith Jr., M. D.

, 19 (Address) Surg Spts., Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Waverly	May 11 1921
20 UNDERTAKER Edw Wiedefeld Jr	ADDRESS 501 E 22

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53620 ✓ 120 D 53620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1905 E. Lanvale ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Hancock

(a) RESIDENCE. NO. 1905 E. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Adaline R. Hanson

6 DATE OF BIRTH (month, day, and year) Feb 6 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter House
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Hancock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Leeke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mary E. Hanson 1905 E. Lanvale

15 Filed MAY 11 1921 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to May 9, 1921, that I last saw h[illegible] alive on May 9, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

7 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

2 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) B. F. Kelly, M. D.

, 19 (Address) 1002 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	May 12, 1921
20 UNDERTAKER Zickler & Zickler	ADDRESS 1739 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53621 ✓ 64 D 53621

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3610 Fairview Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Elizabeth Adams

(a) RESIDENCE. No. 3610 Fairview Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sydney Adams

6 DATE OF BIRTH (month, day, and year) June 12, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know

14 Informant Mrs. H. A. B. Dunning
(Address) 4215 Greenway

15 Filed MAY 11 1921 ROBERT F. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10th, 1921, to May 10th, 1921, that I last saw her alive on May 10th, 1921, and that death occurred, on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) A. C. Summit, M. D.

May 11th 1921 (Address) 4509 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery ~~Greenmount Cemetery~~	May 14/21 19
20 UNDERTAKER Henry W. Mears & Son	ADDRESS 1655 N. Calvert St

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53622

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 53622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 301 Warren Ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Deved

(a) RESIDENCE. No. 301 Warren Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Louise Deved

6 DATE OF BIRTH (month, day, and year) Feb 10 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Sheet Metal and Sash Weight Factory

(c) Name of employer

9 BIRTHPLACE (city or town) Sullivan Co (State or country) New York State

PARENTS

10 NAME OF FATHER Gabriel T Deved

11 BIRTHPLACE OF FATHER (city or town) Sullivan Co (State or country) New York State

12 MAIDEN NAME OF MOTHER Anna Tice

13 BIRTHPLACE OF MOTHER (city or town) Sullivan Co (State or country) New York

14 Informant Louise Deved

(Address) 301 Warren Ave

MAY 11 1921 ROBERT F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 9 1921, that I last saw him alive on May 9 1921, and that death occurred, on the date stated above, at 8. a m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

May 11 1921 (Address) 835 Lytle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK.	MAY 12 1921
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 53623

CERTIFICATE OF DEATH.

GV D 53623

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #425 Hawthorne Road ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Yearley, 3rd.

(a) RESIDENCE. No. 425 Hawthorne Road ST., 27 WARD. (Resident)
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 0 mos. 24 ds. How long in U. S., if of foreign birth? 38 yrs. 0 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Rurant Church

6 DATE OF BIRTH (month, day, and year) April-16-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate.

(b) General nature of industry, business, or establishment in which employed (or employer): Real Estate.

(c) Name of employer: Alex. Yearley-Son

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Alexander Yearley Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Irene Judik

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Thos. B. C. Yearley (uncle)
(Address) #2-[illegible]-Lexington St. City.

15 Filed MAY 11 1921 ROBERT B. KRAUSE Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7 1921, to May 10 1921,
that I last saw h... alive on May 10. '21, 19...,
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia (Typical)

(duration) 6 days

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence only.

(Signed) Earle O'Donovan, M. D.

May 12, 1921 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May-12-1921
20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Halliburton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53624

D 53624

91-089

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 Mullin ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jessie Hollibaston

(Residence in Baltimore: No. 1826 Mullin St.; 12 yrs., ... mos. ..... ds.)

West Fulton Ave. Monroe

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Apr. (Month) 1 (Day), 1907 (Year)

7-AGE, 13 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Philadelphia Pa.

PARENTS.

10-NAME OF FATHER, Joseph Hollibaston

11-BIRTHPLACE OF FATHER (State or Country), Dunbar N. C.

12-MAIDEN NAME OF MOTHER Emma Rodgers

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Jones

(Address) 1826 Mullin St.

15- MAY 11 1921 Filed..... 191... Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4 1921, to May 9 1921, that I saw h[illegible] alive on May 9 - 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Chas. Chas Carter M. D.

May 10, 1921 (Address) 924 N. Stricker St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, MAY 12 1921, 191...

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53625

CERTIFICATE OF DEATH.

28 D 53625

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2307 Guenmount Ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Loring

(a) RESIDENCE. NO. 2307 Guenmount ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M Loring

6 DATE OF BIRTH (month, day, and year) Aug 14 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas A Loring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lovie Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Anna M Loring 2307 Guenmount

MAY 11 1921 ROBERT E LEE BLAND Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-9 1921

17 I HEREBY CERTIFY, That I attended deceased from 1-5, 1920, to 5-9, 1921, that I last saw him alive on May 9, 1921, and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis.

(duration) about 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Exam.

(Signed) J. J. Wakefield, M. D.

, 19 (Address) 1451 E. 22nd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bells Cross	May 11 1921
20 UNDERTAKER	ADDRESS
J Herwig & Co	2008 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital (ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Holland

(a) RESIDENCE. NO. 2010 Jefferson ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER E. P. Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital Baltimore

15 MAY 11 1921 ROBERT J. REGISTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17

I HEREBY CERTIFY, That I attended deceased from 4/17/21, 19 . to 5/10/21, 19 21.

that I last saw him alive on 5/10/21, 19 21,

and that death occurred, on the date stated above, at 7:10 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Pleurisy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Lung Abscess

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 4/26/21

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) A. Blenerale M. D.

5/10, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West View Cemetery Md	May 12 1921
20 UNDERTAKER J. Kemp & Co	ADDRESS 2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53627

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

1-28 D 53627

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST.: Municipal Tuberculosis Hospital 25 WARD)

2-FULL NAME Pattie Smarr

(a) RESIDENCE. No. 8th st., Fairfield, Md. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fred Smarr

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): West Virginia

PARENTS

10 NAME OF FATHER: Chas. Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Florida

12 MAIDEN NAME OF MOTHER: Mary Morax

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Virginia

14 Informant: Hospital Records

(Address): M.T.H.

15 Filed MAY 11 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10, 1921

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1921, to May 10, 1921, that I last saw her alive on May 10, 1921, and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Wm. D. Faulkner, M. D.

5-10-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elderton Greenbrier Co. W. Va	May 13 1921
20 UNDERTAKER	ADDRESS 743
John H. Loadwick	Lisbon St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—3-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53628

CERTIFICATE OF DEATH.

+ 91

D 53628

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Howard A. Kelly Hospital 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Ed. C. D. Marshall

(a) RESIDENCE. No. Shreveport La ST., WARD Shreveport La
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie B. Marshall

6 DATE OF BIRTH (month, day, and year) March 12 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54		1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Freight and Passenger

(b) General nature of industry, business, or establishment in which employed (or employer) agent L. R. & N. Co

(c) Name of employer

9 BIRTHPLACE (city or town) Eminence
(State or country) Kentucky

PARENTS

10 NAME OF FATHER William P. Marshall

11 BIRTHPLACE OF FATHER (city or town) Eminence
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Martha Stockton

13 BIRTHPLACE OF MOTHER (city or town) Frankford
(State or country) Kentucky

14 Informant Lillie B. Marshall
(Address) Shreveport La

15 Filed MAY 11 1921 [redacted] J. KRANTZ Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 1921, to May 10, 1921, that I last saw h[illegible] alive on May 10, 1921, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Prostatic tumor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 0

Did an operation precede death? 0 Date of 0

Was there an autopsy? 0

What test confirmed diagnosis? Cystoscopic examination

(Signed) Dudley A. Roberts, M. D.

, 19 (Address) 1418 Eutaw.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shreveport La	May 11 1921
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. Fourth Ave

MATTER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53629

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53629

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 S. Schroeder ST.; 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Colburn

(Residence in Baltimore: No. 113 S. Schroeder St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Dec (Month) 25 (Day), 1902 (Year)

7-AGE,	If LESS than 1 day,
18 yrs. 4 mos. 13 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Franklin E. Darby

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Laura Gripp

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oliver F. Colburn

(Address) 113 S. Schroeder St.

15- Filed MAY 11 1921, 191.... [illegible] BEAUTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8 (Day), 1921 (Year)
(Month)

17- I HEREBY CERTIFY, That I attended deceased from March 1921, to May 8 1921, that I saw h[illegible] alive on May 8 191..., and that death occurred, on the date stated above, at 6.20 p.m.

The CAUSE OF DEATH* was as follows:

Fatal Coal Gas Poisoning

Accidental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) ....yrs. 2 mos. ....ds.

(Signed) M. E. Campbell M. D.

May 9, 1921, (Address) 604 E. Hamburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral Cemetery	May 12, 1921
20-UNDERTAKER James Bryan & Son	ADDRESS 1000 S. Paca st

N. B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53630

CERTIFICATE OF DEATH.

D 53630

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 E. Cross ST.; 24 WARD) REGISTERED NO. C

2-FULL NAME Rose A Cook

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 412 E Cross St.; ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, March 20, 1844 (Month) (Day) (Year)

7-AGE, 77 yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Jno P Ward.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Mary Cuddy

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas L Cook

(Address) 412 E Cross St

15-

MAY 11 1921 191.. ROBERT A KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2 1920, to May 9th 1921, that I saw her alive on May 9th 1921, and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Duration ... yrs. 10 mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(Duration) ... yrs. ... mos. 2 ds.

(Signed) Henry B Kolb M. D.

May 11, 1921. (Address) 1203 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St. Peters Cem.	May 12, 1921
20-UNDERTAKER Margaret T. Flynn	ADDRESS 1722 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53631

CERTIFICATE OF DEATH.

D 53631

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. J. Agle

(a) RESIDENCE. No. 2033 Frederick Ave ST., 20 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Thos Agle

6 DATE OF BIRTH (month, day, and year) April 11 - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Works

(c) Name of employer Laurel Md

9 BIRTHPLACE (city or town) (State or country) Laurel Md

PARENTS

10 NAME OF FATHER B. Agle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Gallahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Clarence H. Agle
(Address) 2033 Frederick Ave.

15 Filed MAY 11 1921 ROBERT E. LEE Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5 - 1921, to May 9 1921, that I last saw h[illegible] alive on May 9 1921, and that death occurred, on the date stated above, at 11:15 P m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency
Chronic nephritis
Uraemia
(duration) Don't know yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examinations.

(Signed) W. H. Healey M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loyola Cathedral	May 12 1921
20 UNDERTAKER	ADDRESS
Geo Schwab & Bro	201 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

William Prevas

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53632

CERTIFICATE OF DEATH.

104 D 53632

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 Fleet ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Prevas

(a) RESIDENCE. No. 1624 Fleet ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Nicholas Prevas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Evelen Contus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant John Prevas (Address) 1624 Fleet St

15 MAY 11 1921 ROBERT E. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1921, to May 10, 1921, that I last saw him alive on May 10, 1921, and that death occurred, on the date stated above, at 10 45 8 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cirrical Adenitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Apr 26 1921

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) Walter C Bacon M. D.

5/11, 1921 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 11 1921

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Tinson

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 53633

64 D 53633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N. Eden ST.: 5th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Tinsan

(a) RESIDENCE. No. 314 N. Eden ST., 6th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Tinsan

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. Tinsan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Tinsan

(Address) 314 N. Eden St.

15 MAY 11 1921

ROBERTS & SHAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8. 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 8, 1921, that I last saw him alive on May 8, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

5-10, 1921 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 16 '21

20 UNDERTAKER	ADDRESS
R C Gross	1425 McElderry St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

147959
D 53634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 53634

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Nelson

(a) RESIDENCE. No. 519 Lutkard alley St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 dys. How long in U. S., if of foreign birth? ... yrs. ... mos. ... dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None yd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Anna Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Johns Hopkins Hospital Records.

15 MAY 11 1921 BURIAL PERMIT ISSUED Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 — 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4 — , 1921, to May 5 — , 1921, that I last saw her alive on May 5 — , 1921, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) W Davison, M. D.

5-5, 19 21 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	MAY 11 1921
20 UNDERTAKER	ADDRESS

Commissioner Health.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53635

CERTIFICATE OF DEATH.

D 53635

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N. Kenwood Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura V. Fowler

(Residence in Baltimore: No. 5 N. Kenwood Ave. St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 11 (Day), 1850 (Year)

7-AGE, 70 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John P. Fowler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Mary Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lydia Shelde

(Address) 5 N. Kenwood

15- MAY 11 1921 ROBERT A. LAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 (Month) - 10 (Day) - 21 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5-9-21 191..., to 5-10-21 191..., that I saw her alive on 5-10-21 191..., and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary) None

(Duration) ....yrs....mos....ds.

(Signed) H. J. Heinmann M. D.

5-11-21, 191... (Address) 7914 E. Belvedere

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel	May 13, 1921
20-UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53636 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53636

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH Mercy Hospital REGISTERED NO. 4

CITY OF BALTIMORE: (No ..... ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hyatt

(a) RESIDENCE. No. Mercy Hospital ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 1/4 hrs. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 1921

7 AGE	Years	Months	Days	If LESS than 1 day, 2 1/4 hrs. or ..... mln.
	2 1/4 hrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Melvin Hyatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Windsor N. C.

12 MAIDEN NAME OF MOTHER Mary L. Family

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Melvin Hyatt.
(Address) Mercy Hosp.

MAY 11 1921 [illegible] Registrar

Burial Permit Oleph

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 10, 1921, that I last saw h[illegible] alive on May 10, 1921, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. 2 1/4 hrs.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis L. Kearney, M. D.

, 19 (Address) Mercy Hosp. Med. Supt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	May 14 1921
20 UNDERTAKER	ADDRESS
Lilly Ed Zeiler	403 S. Wolfe St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 53637

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 N. Canal Ave ST.: 16 WARD)

2-FULL NAME Clara Eliza Miller.

(a) RESIDENCE. No. 610 N. Canal Ave ST., 16 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Samuel Miller.

6 DATE OF BIRTH (month, day, and year) July 24 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Nazareth Pa.

PARENTS

10 NAME OF FATHER Herman G. Eppert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Maria Finch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Herman Miller (Address) 610 N. Canal Ave

15 Filed MAY 11 1921 ROBERT J. KRAUSE Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10- 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1921, to May 10-, 1921, that I last saw h.. alive on May 10-, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis —

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Albert Gleason, M. D.

May 11 1921 (Address) 827 N. Chester St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
London Park	May 13 1921

20 UNDERTAKER Geo W Little ADDRESS 3700 Edmondson Ave

See instructions on back of certificates. Exact statement of OCCUPA- should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53638

CERTIFICATE OF DEATH

108 D 53638

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mahola McAllister.

(a) RESIDENCE. No. 520 Woodlawn Road ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. McAllister

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bacto Md.

PARENTS

10 NAME OF FATHER Linus Feast

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Durham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John R. McAllister (Address) 520 Woodlawn Ave

15 Filed MAY 11 1921 ROBERT A. KRAUSE Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr 23, 1921, to May 10, 1921, that I last saw h.r alive on May 10, 1921, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Renal Disease

Acute Cholecystitis

Acute Appendicitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr. 23. 1921

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) W. Durham, M. D.

19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem. Phila. Co.	May 12 1921

20 UNDERTAKER John D. Mitchell ADDRESS 1201 W. Fayette

NATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53639

CERTIFICATE OF DEATH.

114 D 53639

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 N Exeter ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hinda Ostrinsky

(a) RESIDENCE. No. 128 N Exeter ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Ostrinsky

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: 48 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Harry Sherach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessie Sherach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Myer - Ostrinsky

(Address) 1362 N Caroline St

15 MAY 11 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1921

17

I HEREBY CERTIFY, That I attended deceased from Apr 4, 1921, to May 10 1921.

that I last saw her alive on May 10, 1921.

and that death occurred, on the date stated above, at 5.40 a.m.

The CAUSE OF DEATH* was as follows: Acute. Nephritis.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Etc

(Signed) Myer A. Weinberg M. D.

. 19 (Address) 1724 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rondale	May 11 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Baltimore

mation should be carefully supplied. AGE should be stated
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 53640

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maud Powell

(a) RESIDENCE. No. 1157 E. Lombard ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Herbert Powell

6 DATE OF BIRTH (month, day, and year) March 4-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cigar maker 917
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant. Rose L. Kuntz
(Address)

15 MAY 11 1921 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1921, to May 10, 1921, that I last saw her alive on May 10, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Uterine pedunculated submucous fibroid

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 6-1921

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) N. T. Lombardi, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	5/11 1921
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53641

CERTIFICATE OF DEATH

150 D 53641

1-PLACE OF DEATH Stagnes Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 13 WARD)

2-FULL NAME Baby Howard

(a) RESIDENCE. No. 3705 Elm ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 1 ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Stagnes.
(State or country)

PARENTS

10 NAME OF FATHER Mr Chas F Howard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balt.

12 MAIDEN NAME OF MOTHER Irma Howard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balt

14 Informant
(Address)

15 FILED APR 22 1921 ROBERT A KRAUTER Registrar

Burial MAY 11 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19....., that I last saw h.....alive on....., 19....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Monstrosity
Child lived one minute (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J K Nichols, M. D.

, 19 (Address) Stagnes Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Carnegie Inst of Embryology Johns Hopkins Hosp. Balto	19

20 UNDERTAKER ..... ADDRESS .....

F H Weitzel & Co

Body sent to Carnegie Research Embryology Johns Hopkins

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53642 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53642

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Stiles ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Corcoran

(a) RESIDENCE. NO. 912 Stiles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? 53 yrs. 6 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 2nd 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Martin Corcoran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ellen Corcoran

(Address) 912 Stiles st

15 Filed MAY 11 1921 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to May 10, 1921.

that I last saw her alive on May 9, 1921,

and that death occurred, on the date stated above, at 9 a, m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine etc

(Signed) E. L. Peregoy, M. D.

May 16 1921 (Address) 2314 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 13th 1921

20 UNDERTAKER Wm C. Miller

ADDRESS 2334 Jefferson

D 53643 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53643

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 136 n Duncan ST.; 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Stichel

(Residence in Baltimore: No. 136 n Duncan St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Baby

6-DATE OF BIRTH, May 11th, 1921
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds.
If LESS than 1 day, 4 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Wm Stichel

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Fritsch

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Stichel

(Address) 136 N. Duncan

15-

Filed MAY 11 1921 Robert P. Harrison, Registrar.

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Knott Hinsley M. D.
(Coroner.)
5-11, 1921 (Address) 7 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Paul	May 12 1921
20-UNDERTAKER Philip Henry	ADDRESS 2016 Aliceanna

Clark

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53644

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Clark

(a) RESIDENCE. No. 620 Gilbert ST., — WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1920

7 AGE — Years: 1 Months: 3 Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Welton Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Helen Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Willian Clark 620 Gilbert St

15 [illegible] Registrar

Burial Permit Clerk.

MAY 11 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 14, 1921, to May 10, 1921, that I last saw h.e.r. alive on May 10, 1921, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms.

(Signed) John Conway M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cem.

DATE OF BURIAL: May 12 1921

20 UNDERTAKER: Felix B. Pope

ADDRESS: 102 E. Mulberry

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53645 ✓ D 53645

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4016 Belle ave. ST.: 15 WARD)

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Hamburger

(a) RESIDENCE. No. 4016 Belle ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Nov. 30-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Levi Stausberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Europe

12 MAIDEN NAME OF MOTHER Carolina Meyers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Europe

14 Informant Jacob Stausberg
(Address) 1111 N. Charles st.

15 Filed MAY 11 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 1920, to May 10, 1921, that I last saw h[e] alive on May 9, 19 1, and that death occurred, on the date stated above, at 10 [illegible]9 m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 10 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J Frederick Lee, M. D.

5/10. 1921 (Address) 2046 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	May 12 1921
20 UNDERTAKER	ADDRESS
J. Adkins & Co	1611 Mad ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

147986 D 53646

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53646

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.. 710 WARD)

2-FULL NAME Grace Buckheimer

(a) RESIDENCE. NO. 3402 Lexington ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Clarence Buckheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) John Hopkins Hospital Records

15 Filed ..... 19 Robert P. Harrison, Registrar

MAY 11 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5 . 1921 . to May 11 . 1921 .

that I last saw h alive on May 11 . 1921 .

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann

(Signed) W. L. Darrin, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	May 13 1921
20 UNDERTAKER Daniel Carbin	ADDRESS 916 Ea all

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53647

CERTIFICATE OF DEATH.

X 28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 741 W. Franklin ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sam. Shulman

(Residence in Baltimore: No. 741 W. Franklin St St.: — yrs., — mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Unknown, 1858
(Month) (Day) (Year)

7-AGE, 63 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired tailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Shulman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Katz

(Address) 741 W. Franklin St.

15-

Robert P. Harrison,

Filed....., 191.....
Registrar.

MAY 11 1921 Burial Permit Clerk

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 5th 1921, to May 10 1921, that I saw him alive on May 10th 1921, and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonary tuberculosis

Indefinite (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Tubercular pneumonia

(Duration)....yrs....mos. 1 ds.

(Signed) Benj. Nadler M. D.

....., 191... (Address) 252 N. Payson St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence St. Louis Mo.

19-PLACE OF BURIAL OR REMOVAL, St. Louis Mo. DATE OF BURIAL, May 11, 1921

20-UNDERTAKER Earl Levin, ADDRESS ~~May St~~ 1411 E. Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53648

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53648

CERTIFICATE OF DEATH.

1920

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Moore ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca James

(a) RESIDENCE. No. 411 Moore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Delaware James

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 70				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton, Md.

PARENTS

10 NAME OF FATHER Isaac Madden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co. Md

12 MAIDEN NAME OF MOTHER Mary Hyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co.

14 Informant (Address) Delaware James 411 Moore

15 Filed MAY 12 1921 ROBERT J. BRAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 10, 1921, to May 10, 1921, that I last saw h.. alive on May 9, 1921, and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Auto-toxemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis 5 or 6 mos + (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. H. Tompsmon M. D.

19 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Mem	May 13 1921
20 UNDERTAKER Sam'l W. Chase Sons	ADDRESS 1400 Mosher St

D 53649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53649

CERTIFICATE OF DEATH.

X 175 001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.: 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Davis Joyner

(Residence in Baltimore: No. Rock Hall Md St.; yrs., mos. 3 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug (Month) 14 (Day) 1906 (Year)

7-AGE, 14 yrs. 8 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Joyner

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriet S Davis

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Joyner

(Address) Rock Hall Md

15-

FILED MAY 12 1921 191.... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 11 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fell from auto truck, wheel passed over his abdomen.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Accidentally fell from truck

(Duration) yrs. mos. ds.

(Signed) W K Grimes M. D. (Coroner.)

5-11, 1921. (Address) 117 W Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 3 ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Rock Hall Md

19-PLACE OF BURIAL OR REMOVAL, Rock Hall Md — DATE OF BURIAL, 5-14-21

20-UNDERTAKER, Em. Robert & Son — ADDRESS 2303 Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53650

CERTIFICATE OF DEATH.

37 D 53650

1-PLACE OF DEATH Robert Garrett Hosp for Children REGISTERED NO.

CITY OF BALTIMORE: (No. 27 N. Carey ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Hands

(a) RESIDENCE. No. 1710 Cole ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 11 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Wm H Hands

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lexington md

12 MAIDEN NAME OF MOTHER A.K. Hard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salisbury md

14 Informant Wm H. Hands
(Address) 1710 Cole St

15 MAY 12 1921 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jany 23rd 21, to May 11th 21, that I last saw him alive on May 11th 21, and that death occurred, on the date stated above, at 5 20 8 m.

The CAUSE OF DEATH* was as follows:

Hereditary Syphilis

(duration) life yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary T.B.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Biological & Physical & Chemical

(Signed) J. W. V. Clift, M. D.

5/11, 1921 (Address) 27 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge M.E. Cem	May 13 1921
20 UNDERTAKER Roberts Brookmeyer	ADDRESS 732 Calhoun

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53651

64 D 53651

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 337 W Preston St. 11 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Johnson

(a) RESIDENCE. No. 337 W Preston St. Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 5 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 12, 1876

7 AGE 44 Years 5 Months 27 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jesse Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Emma Johnson

(Address) 337 W. Preston St

MAY 12 1921

Burial Permit Issued

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1921 to May 9, 1921, that I last saw h[illegible] alive on May 9, 1921, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Chas P. Clautice M. D.

1921 (Address) 1501 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 12 1921
20 UNDERTAKER	ADDRESS
Geo T. A. Gibson	513 Fairmount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53652

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 726 N. Mount St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Rott

(Residence in Baltimore: No. 726 N. Mount St.: 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	married

6-DATE OF BIRTH, May 6, 1868
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day, ...hrs. or....min.?
53 yrs. mos. 4 ds.	

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chaircaner (blind)
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mc. Boone

(Address) 444 N. Fremont Ave

15- Filed MAY 12 1921, 191... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. T. Heuisler M. D.
(Coroner.)

May 12, 1921 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, 5/12/21

20-UNDERTAKER Geo J Smith ADDRESS 1000 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-12—H. P. Co.—1000 Bks.

D 53653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 53653

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 West Lee St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie E. Briggs

(a) RESIDENCE. No. 536 W. Lee St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26-1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Ernest Briggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Beatrice Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Beatrice Briggs
(Address) 536 W Lee St

15 MAY 12 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1921, to May 9, 1921, that I last saw her alive on May 9, 1921, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) 9 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. K. Hance, M. D.

May 11 1921 (Address) 712 S Bond Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL May 12 1921

20 UNDERTAKER John H. Toadvine — ADDRESS Ustick

IMPORTANT: Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sarah E. Trago

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53654

CERTIFICATE OF DEATH.

120 D 53654

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 n Potomac St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Trago.

(a) RESIDENCE. NO. 143 n Potomac ST.; WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Trago

6 DATE OF BIRTH (month, day, and year) Oct 10 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
(48)	48	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward Sullens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick, Md.

12 MAIDEN NAME OF MOTHER Catherine Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Catherine Archer
(Address) 143 N. Potomac St.

15 MAY 12 1921 ROBERT F. LEAUTEY Registrar

Burial ... Clock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 21, to May 10, 1921, that I last saw her alive on May 10, 21, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? don't know

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Knott Insley, M. D.

. 19 (Address) 2958 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	May 13 1921
20 UNDERTAKER	ADDRESS
H. Sanders Sons	1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

Jesse B. Davis

HEALTH DEPARTMENT—CITY OF BALTIMORE

53655

CERTIFICATE OF DEATH.

28 D 53655

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 Woodbourne Ave ST.; 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Brody Davis.

(a) RESIDENCE. No. 636 Woodbourne Ave ST.,

WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma Geist.

6 DATE OF BIRTH (month, day, and year) December 31st 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jessie Davis.

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Martha V. Brady

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Va.

14 Informant Emma Davis
(Address) 636 Woodbourne Ave

15 MAY 12 1921 ROBERT J. KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 1921

17

I HEREBY CERTIFY, That I attended deceased from January 15th, 1921, to May 10th, 1921,
that I last saw h... alive on May 10th, 1921,
and that death occurred, on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Geo. Ungerott M.D. M. D.

May 10 1921 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 13 1921
20 UNDERTAKER	ADDRESS
John Henry & Co	2008 Orleans

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53656

CERTIFICATE OF DEATH.

29 D 53656

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Flemming

(a) RESIDENCE. No. Preston & Valley Sts. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Flemming.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Sheridan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence

(Address) Preston & Valley

15 Filed MAY 12 1921 ROBERT J. KRAUTH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1920, to , 19 ,

that I last saw her alive on May 8 , 1921,

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile gangrene of heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

May 11, 1921 (Signed) F. A. Warner, M. D.

(Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 14, 1921

20 UNDERTAKER H. C. Warfield & Grunert Bro. ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53657

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1937 Ridgewood ST.: 15 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George William Peyton

(a) RESIDENCE. No. 1937 Ridgewood ST., 15 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Ida May Peyton

6 DATE OF BIRTH (month, day, and year) Nov 18 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Flagman

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R. R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Clark Knipp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Ida May Peyton

(Address) 1937 Ridgewood Ave

15 MAY 12 1921 ROBERT A. LEAUTEY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to May 10, 1921, that I last saw h.m. alive on May 9, 1921, and that death occurred, on the date stated above, at 8.50 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred C Jewett, M. D.

19 (Address) 254 E Pennsa ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	May 13 1921

20 UNDERTAKER Josiah Syfer ADDRESS 1606 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1009 Bks.

D 53658

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53658

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 210 N Monroe ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah . R. Ford

(a) RESIDENCE. No. 210 N Monroe ST., 20 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas S Ford

6 DATE OF BIRTH (month, day, and year) June 10 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Rob Alexandra

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas S Ford

(Address) 210 N Monroe St

15 Filed MAY 12 1921 . 19 ROBERT A. LAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17

I HEREBY CERTIFY, That I attended deceased from May 9th, 1921, to May 11th, 1921, that I last saw h[illegible] alive on May 11th 1921, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis OVER

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) By Dr Cleary, M. D.

, 19 (Address) 400 W Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	May 14 19 21
20 UNDERTAKER	ADDRESS
Sarah Taylor Undertaker	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 53659

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3401 Fait Av ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara C. Beil

(a) RESIDENCE. NO. 3401 Fait Av ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Beil.

6 DATE OF BIRTH (month, day, and year) Dec. 29-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John B Ehent.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Anthony Beil.

(Address) 3401 Fait Ave

15 [illegible] MAY 12 1921 [illegible] Registrar

Burial [illegible] Sept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 1919, to May 10th, 1921.

That I last saw her alive on May 10, 1921.

and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) 2 yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Not Known

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Schwatka, M. D.

5/12/1921 (Address) 734 S Edward Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	May 13 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeile	403 S. Mo[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53660

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 53660

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 810 S. Curley ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Kurowski.

(a) RESIDENCE. NO. 810 S. Curley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	11	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work attended school.

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Kurowski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Anna Zecek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Anna Kurowski

(Address) 810 S. Curley St.

15 MAY 12 1921 ROBERT E. LAZZELL Registrar

Burial ... Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1921, to May 11, 1921, that I last saw h... alive on May 11, 1921, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Inflamatory Rheumatism

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas B. Tilton M. D.

5/12 1921 (Address) 315 S. Highland Ave.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	May 14 1921
20 UNDERTAKER	ADDRESS
Lilly & Zuke	403 S. Mo... St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Loety

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53661

CERTIFICATE OF DEATH.

50 ✓ D 53661

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST.. WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Loety

(a) RESIDENCE. No. 569 Caton Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Julius A Loety

6 DATE OF BIRTH (month, day, and year) May 8-1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	-	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Justis Muller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Julius F. Loety

(Address) 569 Caton Ave

15 MAY 12 1921 ROBERT J. KRAUTER Registrar

Burial Permit Oleck

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-11 1921

17

I HEREBY CERTIFY, That I attended deceased from 5-5, 1921, to 5-11, 1921, that I last saw h[illegible] alive on 5-11, 1921, and that death occurred, on the date stated above, at 1 17 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis - Coma

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. McK. Craig, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 14 1921
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 ✓ D 53662

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Ashburton ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie V Fowry

(a) RESIDENCE. No. 1125 Ashburton ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred? Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan-9-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Oliver E. Bushman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jamie Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant E. J. Hearn

(Address) 138 N. Potomac

15 Filed MAY 12 1921 LOREE F. LEAUTER Burial Permit Clerk

Dr Shannon 700 N. Fulton

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 11, 1921, that I last saw h[illegible] alive on May 10, 1921, and that death occurred, on the date stated above, at 1745 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Geo. E. Shannon, M. D.

5/11, 1921 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 14 1921
20 UNDERTAKER William Cook	ADDRESS 508 E Wall

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. Hennessy

D 53663

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 53663

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1023 Madison Ave ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Gardner

(Residence in Baltimore: No. 1023 Madison Ave St. 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH. Feb. (Month) 23 (Day), 1846 (Year)

7-AGE. 75 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): Hd

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. William Linin

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER Nancy Cook

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F Gaskie

(Address) 1023 Madison Ave

15- MAY 12 1921 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (15 minutes)

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

May 11, 1921 (Address) 2817 Edmondson Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park — DATE OF BURIAL. May 13, 1921

20-UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

N. B.—Every item of information should be carefully supplied. ACCURACY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53664

CERTIFICATE OF DEATH.

40 D 53664

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 W. Lexington ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Farriel Kaladner

(a) RESIDENCE. No. 1011 W. Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida -

6 DATE OF BIRTH (month, day, and year) Century

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Bernard Kaladner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Minnie Kaladner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Kerns 1411 E. Balto. St

15 FILED MAY 12 1921 ROBERT J. BEAUTH Registrar Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 20 1921 to May 11 1921, that I last saw h alive on May 11 1921 and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Liver (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) a Uremia (duration) yrs. mos. 14 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray Physical

(Signed) J. H. Thomas M. D.

May 12 1921 (Address) 1228 E Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rossdale	May 12 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Bal

Spec.—6-9-19—H P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53665 — 79 ✓ — D 53665

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Orleans St.; 5 Ward) — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Hilliard

(a) RESIDENCE. No. 1416 Orleans St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Hilliard

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — General Dom

(b) General nature of industry, business, or establishment in which employed (or employer) — Domestic

(c) Name of employer — none

9 BIRTHPLACE (city or town) (State or country) — Balto Md.

PARENTS

10 NAME OF FATHER — Joseph Hardie

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Trinidad B. W. I.

12 MAIDEN NAME OF MOTHER — Harriet Hardie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Balto Md

14 Informant — Hattie Kane

(Address) 1416 Orleans St

15 MAY 12 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1921

17

I HEREBY CERTIFY, That I attended deceased from 5/5, 1921, to 5/9, 1921, that I last saw h[illegible] alive on May 9, 1921, and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Robinson, M. D.

5/9, 1921 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	May 12 1921

20 UNDERTAKER Wm. F. Kemsley — ADDRESS 1811 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement as to OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53666

CERTIFICATE OF DEATH.

28 D 53666

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1023 N Chapel St.; 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George Slaughter

(Residence in Baltimore: No. 1023 N Chapel St.

40 ~~10~~ St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widower

6-DATE OF BIRTH, Unknown, 1865
(Month) (Day) (Year)

7-AGE, 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hod Carrier
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Penna

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Starks

(Address) 1023 N Chapel

15 MAY 12 1921 ROBERT B KRAUTH

Filed ..... 191 .... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Kirk Smiley M. D.
(Coroner)

5-11, 192 (Address) 4 E. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park | DATE OF BURIAL, May 12 1921

20-UNDERTAKER, Isaac C. Stevenson & Son | ADDRESS 538 N. Eutaw

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 53667

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Bolton ST.: 11 WARD)

2-FULL NAME Dra Day Miller

(a) RESIDENCE. No. 1204 Bolton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Pa. R.R.

9 BIRTHPLACE (city or town) (State or country): York Springs Pa

PARENTS

10 NAME OF FATHER: Charles Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Elmira Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Mrs Florence D Day

(Address) 1204 Bolton St

15 MAY 12 1921 BOWIE & TRACEY Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1921, to May 10, 1921, that I last saw him alive on May 10, 1921, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease following acute nephritis probably (duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albumen casts, uraemic coma

(Signed) Armando J Nosti, M. D.

, 19 (Address) 210 West 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
York Springs Pa	May 13 1921
20 UNDERTAKER: Wm J Pickney & Sons	ADDRESS: Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 53668

CERTIFICATE OF DEATH

28 D 53668

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 3 N. Belnord Ave. ST.: 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William Thomas

(Residence in Baltimore: No. 3 N. Belnord Ave. If not in Baltimore, how long in State ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Col.

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: Oct. 13, 1880 (Month) (Day) (Year)

7 AGE: 40 yrs. 6 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Ind.

PARENTS

10 NAME OF FATHER: William G. Thomas

11 BIRTHPLACE OF FATHER (State or country): Ind.

12 MAIDEN NAME OF MOTHER: Sarah E. Bromwade

13 BIRTHPLACE OF MOTHER (State or country): Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. Emma Thomas

(Address) 3 N. Belnord Ave

15 Filed MAY 12 1921 ROBERT J. BEAUTH Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May 9, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to May 9, 1921, that I saw him alive on May 8, 1921, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Laryngeal & Pulmonary Tuberculosis

(Duration) — yrs. 2 mos. ..... ds

Contributory (SECONDARY) Cord and Exhaustion

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Wm. E. McDonald M. D.

5/9/21 (Address) 1323 Parkin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Cedar Hill Cem.

DATE OF BURIAL: 5-12-1921.

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53669

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH 503 N. Port St

REGISTERED NO.

CITY OF BALTIMORE: (No. 503 N. Port ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mame Alma Beak

(a) RESIDENCE. No. 503 N. Port ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Beak

6 DATE OF BIRTH (month, day, and year) Jan 11 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John A. Busse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ella W Flaherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Husband Albert Beak
(Address) 503 N. Port St

15 [illegible] MAY 12 1921. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/ 1921.

17 I HEREBY CERTIFY, That I attended deceased from Mar 31, 1921, to May 10, 1921, that I last saw her alive on May 10, 1921, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

OVER

(duration) — yrs. mos. 41 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 41 ds.

18 Where was disease contracted if not at place of death? Her home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary + Clinical

(Signed) A. W. Macdonald, M. D.

May 11, 1921 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	5-13 1921
20 UNDERTAKER J. G. Moran	ADDRESS 300 E Baltimore

REFUSE SPACE IN CAPTIONS BELOW IT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Groecry;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc.. when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Aceidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53670

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4200 Liberty Heights Ave. ST.; 28 WARD)

REGISTERED NO. 109

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Graves Lentz

(a) RESIDENCE. No. 4200 Liberty Heights Ave. WARD.

(Usual place of abode) (Resident)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 25 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 7 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Georg Lentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Margaret Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md

14 Informant Mrs Sarah C Gross (aunt)
(Address) 4200 Liberty Heights Ave.

15 Filed MAY 12 1921, 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17

I HEREBY CERTIFY, That I attended deceased from May 6, 1921, to May 12, 1921, that I last saw him alive on May 11, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Intussusception (Intestinal Obstruction)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Norbert C Fetsch, M. D.

May 12, 1921 (Address) 2151 Nelson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 12 1921

20 UNDERTAKER Edward M Smith (D D Wordes Assistant)

ADDRESS 1010 N Mt. Ave.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D 53671

HEALTH DEPARTMENT—CITY OF BALTIMORE

1040 D 53671

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Harvey ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Cicero.

(a) RESIDENCE. NO. 703 Harvey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 23. 1921.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Frank Cicero.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Palem Italy.

12 MAIDEN NAME OF MOTHER Barbara Haughnagel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md.

14 Informant Frank Cicero
(Address) 703 Harvy

15 Filed MAY 12 1921, 19 ROBERT P. KRAUTH Registrar
Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1921, to May 11, 1921, that I last saw h— alive on May 10, 1921, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Wm. F. Healey, M. D.

5/11, 1921 (Address) 638 Font.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents Cem.	May 12 1921
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

MAY 12 1921

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 D 53672

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 E. Woodland Ave. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Prof. Wm. H. Zimmerman

(a) RESIDENCE. No. 18 E. Woodland Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Nelson Zimmerman

6 DATE OF BIRTH (month, day, and year) Oct. 19" 1839

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
81	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Prof. of Natural Sciences (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co., Md.

PARENTS

10 NAME OF FATHER George Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth McDaniel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Manockary Frederick Co., Md.

14 Informant May Zimmerman Timanus
(Address) 1307 Maryland Ave.

15 Filed MAY 12 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10" 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2 1921, to to May 10, 1921, that I last saw him alive on May 10, 1921, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis about (duration) one yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? ordinary

(Signed) John F. Monaghan, M. D.

(Address) 1002 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	May 14 1921
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N. Balto St.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53673

CERTIFICATE OF DEATH.

D 53673

130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 Hollins St. ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca E. Lowdenslager

(a) RESIDENCE. NO. 1301 Hollins St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Lowdenslager

6 DATE OF BIRTH (month, day, and year) Jan. 2nd 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Rothrock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ann M. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Rowland Lowdenslager
(Address) 1301 Hollins St.

15 Filed MAY 12 1921, 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/3/21, 19..., to 5/11/21, 19..., that I last saw h[illegible] alive on 5/10/21, 19..., and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum
Exhaustion

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. (?) mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 14th 1921
20 UNDERTAKER	ADDRESS
Joseph L. B. Cook	1003 N. Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53674

CERTIFICATE OF DEATH.

157 D 53674

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 513 N Milly ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H Johnson

(Residence in Baltimore: No. 513 N Milly St 12 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Divorced

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 53 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Kent Kent

12-MAIDEN NAME OF MOTHER, Kent Kent

13-BIRTHPLACE OF MOTHER (State or Country), Kent Kent

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas Holtu Johnson

(Address) 244 9th St N.E. Washington D.C

15-

FILED MAY 12 1921 191.....

ROBERT J. KRAUTH Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to Hi death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Hanging

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Insanity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Jones M. D. (Coroner.)

5-11, 1921 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL: Mt Jackson Va — DATE OF BURIAL, May 12th 1921

20-UNDERTAKER: A. Jones — ADDRESS: 207 S. Sharp

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

(Waszak)

D 53675

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175-001 D 53675

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Gt. Josh. Hospital ST. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frodk Waszak.

(Residence in Baltimore: No. 407 Luce, St., 4 yrs., 10 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Boy

6-DATE OF BIRTH. June 4 — (Month) (Day), 1916 (Year)

7-AGE. 4 yrs. 10 mos. 7 ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. —
(b) General nature of industry, business, or establishment in which employed (or employer). —

9-BIRTHPLACE. (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Joseph Waszak

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Agata Sidor

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Waszak

(Address) 467 S Wolfe St

15- MAY 12 1921 ... 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 10 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Fr by Accl.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) H Rust Dooley M. D. (Coroner.)

5-11-, 1921. (Address) 7 E. Lex.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St. Stanislaus.	May 13, 1921.
20-UNDERTAKER	ADDRESS
M F. Sadowski	405 S. Ann St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53676

D 53676

CERTIFICATE OF DEATH.

147 5-96

37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE; (No. Johns Hopkins Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Krumpelmann

(a) RESIDENCE. No. 1319 N Dallas St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Krumpelmann

6 DATE OF BIRTH (month, day, and year) March 4 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Krumpelmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Adele Rothansen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAY 12 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 18 1921, to May 12 1921, that I last saw him alive on May 12 1921, and that death occurred, on the date stated above, at 2.15 a m.

The CAUSE OF DEATH* was as follows:

Syphilis, syphilis of the liver, interstitial nephritis, Myocardial insufficiency

..... (duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Fibrinous pericarditis

..... (duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V K Mason, M. D.

5-12-21 19 (Address) Res Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 16 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1301 E Oager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 53677

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 Madison Ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Kendall

(a) RESIDENCE. NO. 1301 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. about mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of George Kendall.

6 DATE OF BIRTH (month, day, and year) April 9-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER David Dismore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Maryland

14 Informant Miss Lydia Kendall
(Address) 1301 Madison ave

15 Filed MAY 12 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to May 11, 1921, that I last saw her alive on May 10, 1921, and that death occurred, on the date stated above, at 2:55 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) C. D. Meer, M. D.

5/11/21 19 (Address) 408 S Patterson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 13 1921
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53678

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St.: 24 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Welsh

(a) RESIDENCE. No. 1405 Battery Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 25, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist 076

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mutual Chemical Co.

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Patrick R. Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elizabeth Brandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Howard Welsh

(Address) 1405 Battery Ave.

15 Filed May 12 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1921, to May 10, 1921, that I last saw h.im alive on May 10, 1921, and that death occurred, on the date stated above, at 9:55 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Ruptured Appendix

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bromwell, M. D.

(Address) St Jos. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 13 1921
20 UNDERTAKER	ADDRESS
Margaret T. Flynn	1427 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 12 1921

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53679

CERTIFICATE OF DEATH.

28 D 53679

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 Fough. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Mateja

(a) RESIDENCE. No. 1627 Fough. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ann Mateja

6 DATE OF BIRTH (month, day, and year) July 30, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edward Mateja

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Teodisia Gurawska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs L Dunleavy
(Address) 1627 Fough St.

15 Filed MAY 13 1921 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1921, to May 11, 1921, that I last saw him alive on May 11, 1921, and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A L Dunleavy, M. D.

5/12, 1921 (Address) 2013 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	May 14 1921
20 UNDERTAKER	ADDRESS
Jacob Diehl Co	425 S Conkling

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53680

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 53680

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 W. Hoffman St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha E Brodie

(Residence in Baltimore: No. 535 W Hoffman St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) Unknown (Day), 1876 (Year)

7-AGE, 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Not given

11-BIRTHPLACE OF FATHER (State or Country), Not given

12-MAIDEN NAME OF MOTHER Not given

13-BIRTHPLACE OF MOTHER (State or Country), Not given

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Sadie Brock

(Address)..... 535 W Hoffman

15- Filed MAY 13 1921 ROBERT F. BRAUTEX Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 14 1921, to May 11 1921, that I saw h[illegible] alive on May 10 1921, and that death occurred, on the date stated above, at 4:10 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza

..... (Duration)..... yrs. ..... mos. ..... ds.

(Signed) Edward Stout M. D.

May 12, 1921 (Address) 513 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Auburn Cemetery	May 14, 1921
20-UNDERTAKER	ADDRESS
John H. Tadmire	1920 Pitt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D 53681

REGISTERED NO.

1-PLACE OF DEATH 1621 Walker St.

CITY OF BALTIMORE: (No ~~1410 W. Lombard St.~~ ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola R. Mitchell

(a) RESIDENCE. No. 1621 Walker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William M. Mitchell

6 DATE OF BIRTH (month, day, and year) ~~Jan~~ Colored 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General 37

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Phillip Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William M. Mitchell (Address) 1621 Walker St

15 Filed MAY 13 1921 19 ROBERT E. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from 2/13, 19 21, to May 11, 19 21, that I last saw her alive on May 11, 19 21, and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH* was as follows: Phthisis pulmonalis

(duration) yrs. 3 mos. 28 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno B Johnson M. D.

19 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 14 1921
20 UNDERTAKER Samuel Hemsley	ADDRESS 678 W Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day or a year, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53682

CERTIFICATE OF DEATH.

D 53682

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Russell & Center sts ST.; 25 WARD) Wor Mines 91

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie Murdock

(Residence in Baltimore: No. Russell & Center sts St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, Unknown ....., 1857
(Month) (Day) (Year)

7-AGE, 64 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, David Downes

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles T. Parker

(Address) Wor Mines

15-Filed MAY.13 1921, 191... BOARD OF HEALTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 7 1921, to May 11 1921, that I saw her alive on May 11 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 6 .... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos S Hall M. D.

....., 191... (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, May 15, 1921

20-UNDERTAKER Samuel S. Hemsley ADDRESS 578 N Bridge St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Scheinberg

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53683

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Scheinberg

(a) RESIDENCE. NO. 1800 N. Appleton ST. WARD. New York.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 14 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) New York (State or country) N.Y.

PARENTS

10 NAME OF FATHER Jacob

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Scheinberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Scheinberg (Address) 1800 Appleton St.

15 MAY 13 1921 ROBERT R KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 24, 1921, to May 12, 1921, that I last saw h[illegible] alive on May 12, 1921, and that death occurred, on the date stated above, at 10.00 A m.

The CAUSE OF DEATH* was as follows:

Pericarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frances L. Feeney, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt-Carmel	May 13 1921

20 UNDERTAKER Jacob Levin ADDRESS 1411 E. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30 D 53684

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Strother

(a) RESIDENCE. NO. 1137 Etting ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant David Easton
(Address) 916 Penna Ave.

15 Filed MAY 13 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/1921

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1921, to May 12, 1921, that I last saw her alive on May 12, 1921, and that death occurred, on the date stated above, at 1.10 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy + Symptoms

(Signed) Chas A Mongan, M. D.

. 19 (Address) 5-E Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oman Cook Va	May 13 1921
20 UNDERTAKER Daniel Easton	ADDRESS 916 Penna Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53685 D 53685

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 17 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marjorie Lee O'Brien

(Residence in Baltimore: No. 2143 Huntingdon Ave St.; 16 yrs., 9 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug. 7, 1904. (Month) (Day) (Year)

7-AGE, 16 yrs. 9 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Telephone operator
(b) General nature of industry, business, or estsblishment in which employed (or employer) Bell Co

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Wm. C. O'Brien

11-BIRTHPLACE OF FATHER (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER Ada A. Bell

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. C. O'Brien

(Address) 2143 Huntingdon Ave.

15- MAY 13 1921 Filed....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 29 1921, to May 11 1921, that I saw h[illegible] alive on May 11 1921, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) 4 yrs. 4 mos. 15 ds.

CONTRIBUTORY (Secondary) Typhoid fever and toxemia (Duration) 4 yrs. 4 mos. 3 ds.

(Signed) P. Bidstrup M. D.

5/11....., 1921. (Address) 1124 W. Lafayette Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 12 ds. In the State 16 yrs. 9 mos. 15 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, 5/14....., 1921.

20-UNDERTAKER J. W. Bell & S. Poppleton ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53686

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53686

CERTIFICATE OF DEATH.

126

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen M. Norwood (Norwood)

(a) RESIDENCE. NO. 1725 Madison Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? -- yrs. -- mos. -- ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Higgins

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77.	5	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York.
(State or country)

PARENTS

10 NAME OF FATHER Francis Norwood

11 BIRTHPLACE OF FATHER (city or town) New York.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Bush.

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 Informant Adelaide Norwood
(Address) Cleveland, Ohio

15 Filed MAY 13 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1921.

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to May 12, 1921, that I last saw h. l. alive on May 12, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy. 7

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis & Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 7

Did an operation precede death? Yes Date of May 9 21.

Was there an autopsy? Partial autopsy

What test confirmed diagnosis?

(Signed) D. J. Cassagrande, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	5/14 1921
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53687

CERTIFICATE OF DEATH.

104 D 53687

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 E. Hamburg St. ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Myers.

(a) RESIDENCE. NO. 9 E. Hamburg St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? 38 yrs. 2 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna (Kimball) Myers.

6 DATE OF BIRTH (month, day, and year) Feb, 27, 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Box maker. 086

(b) General nature of Industry, business, or establishment in which employed (or employer): glass works.

(c) Name of employer: Swindell Bros.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Frederick Myers.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland.

12 MAIDEN NAME OF MOTHER Annie Hinkle.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland.

14 Informant: Edna Myers. (wife)

(Address) 9 E. Hamburg St.

15 Filed MAY 13 1921 (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1921, to May 10 1921.

that I last saw him alive on May 10th. 1921.

and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Intussusception.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Asthenia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. M. Reinhardt, M. D.

5/11 1921 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	5/13 1921
20 UNDERTAKER	ADDRESS
L. Fen McCully	130 E. Fort Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53688

D 53688

CERTIFICATE OF DEATH.

91-089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 Lewis St ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Hill

(a) RESIDENCE. NO. 300 Lewis St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) — 1911

7 AGE 10 Years — Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) School Girl

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER Richard R Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Long Green Md

12 MAIDEN NAME OF MOTHER Marlenia Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Richard R. Hill

(Address) 300 Lewis St

15 Filed MAY 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-10-1921

17 I HEREBY CERTIFY, That I attended deceased from May 8 — 1921, to May 10 — 1921, that I last saw her alive on May 10 1921, and that death occurred, on the date stated above, at 9. P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

+ Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis + Pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. H Kennard M. D.

5-12 1924 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL May 13 1921

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS [illegible] Eastland Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53639

CERTIFICATE OF DEATH.

79 D 53689

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 902 Donnelly St. 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Green

(Residence in Baltimore: No. 902 Donnelly Ct 33 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fem'a	Col.	Widow

6-DATE OF BIRTH. ....., 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
52 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... House Work

9-BIRTHPLACE. (State or Country) born in West Va lived in Balt 33 years

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Johnson

(Address) 902 Donly Court

15- MAY 13 1921 Filed....., 191.....

ROBERT J. KRAFFT Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) 10 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) C. H. Knapp M. D.
(Coroner.)

5-11, 1921 (Address) 4 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	May 13, 1921
20-UNDERTAKER	ADDRESS
Mrs Robert A Elliott	726 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53690

CERTIFICATE OF DEATH.

REGISTERED NO. 17 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 Pearl St ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Burris

(a) RESIDENCE. NO. 403 Pearl St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Blk	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peterson Burris

6 DATE OF BIRTH (month, day, and year) Feby 19-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	2 2 1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

Lived in this City 30 yrs

PARENTS

10 NAME OF FATHER Lewis Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Md

12 MAIDEN NAME OF MOTHER Matilda Ayres

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Miranda Williams Towson Md

15 Filed MAY 13 1921 ROBERT S. BRUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feby 14 1919, to May 12 1921, that I last saw h[illegible] alive on May 11th 1921, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? — no

What test confirmed diagnosis?

(Signed) Gustav Fohrman, M. D.

, 19 (Address) 856 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 15 1921
20 UNDERTAKER Dora R A Elliott	ADDRESS 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53691

CERTIFICATE OF DEATH.

45 D 53691

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 S. Paca St - ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph. W. Mc Giff Sr

(a) RESIDENCE. NO. 929 S Paca St - ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	white.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Mary Mc Giff.

6 DATE OF BIRTH (month, day, and year) Unknown. 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith. Helper.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer General Electric Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Patrick Mc. Giff.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Elizabeth Regan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Mc. Giff.
(Address) 929 S Paca St.

15 Filed MAY 13 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1 1921 to May 12 1921 that I last saw him alive on May 11 1921 and that death occurred, on the date stated above, at 7 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma - Abdominal.

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Carcinoma.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? — No —.

What test confirmed diagnosis? Clinical

(Signed) M. C. Finnegan, M. D.

1.24 (Address) 852 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem.	May 14 1921
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hollins St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53692 — 92 — D 53692

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1651 N. Monroe ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Ann Tilton

(a) RESIDENCE. No. 1651 N. Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of - John H. Tilton

6 DATE OF BIRTH (month, day, and year) May 2, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
-	80	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None add

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bakersville, N. J.

PARENTS

10 NAME OF FATHER Reuben Frambes

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Sarah Somers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Mrs Ephrenia Parkwood (Address) 1651 N. Monroe St.

15 Filed MAY 13 1921 ROBT. J. TAYLOR Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to May 11, 1921, that I last saw h... alive on May 11, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? 1651 N. Monroe St

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John D. Quinn, M. D.

May 12 1921 (Address) 1507 N. Fulton Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	May 13 1921
20 UNDERTAKER	ADDRESS
J Nevins & Co	2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53693

CERTIFICATE OF DEATH.

120 D 53693

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnus' Hospital. St.: 25 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Frederick Habighurst

(a) RESIDENCE. No. 1620 Bolton Street St., 14 Ward. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 77 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Habighurst

6 DATE OF BIRTH (month, day, and year) Nov-22-1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(h) General nature of industry, business, or establishment in which employed (or employer): Printing

(c) Name of employer: (self)

9 BIRTHPLACE (city or town) Rouen
(State or country) France

PARENTS

10 NAME OF FATHER Fred. Habighurst

11 BIRTHPLACE OF FATHER (city or town) ? ?
(State or country) France

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) NotKnown
(State or country) France

14 Informant Mrs. M. A. Habighurst (wife)
(Address) #1620 Bolton St., City.

15 Filed MAY 13 1921 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 19 21

17 I HEREBY CERTIFY, That I attended deceased from Mar. 23, 19 21, to May 12, 19 21,
that I last saw h.e.m alive on May 12, 19 21,
and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
Chronic, myocarditis
General arteriosclerosis
(duration) Don't know ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) W. M. Craig R.N.M., M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May-14-1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53694 D 53694

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Enson ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Justice Stahn

(a) RESIDENCE. No. 506 Enson ST., WARD. 11th

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Adaline C. Stahn

6 DATE OF BIRTH (month, day, and year) Dec 17. 1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchmaker & Optician

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer Employer.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Matthias Stahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Lentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Darmstadt Germany

14 Informant Mrs Adaline C. Stahn

(Address) 506 Enson St

15 Filed MAY 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17

I HEREBY CERTIFY, That I attended ~~deceased~~ from about Mar 1914, to May 11th 1921, that I last saw ~~he~~ alive on May 11 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Contusion of the Liver and Chronic interstitial Nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic examination

(Signed) Wm. H. Myers, M. D.

. 19 (Address) 6 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 14 1921

20 UNDERTAKER Frank B. Spencer ADDRESS 1325 N. Caroline St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53695

CERTIFICATE OF DEATH.

91 D 53695

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Guilford ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred J Buckingham

(a) RESIDENCE. No. 1714 Guilford ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma M Buckingham

6 DATE OF BIRTH (month, day, and year) March 6 53

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banking Broker

(b) General nature of industry, business, or establishment in which employed (or employer) Trust Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md.

PARENTS

10 NAME OF FATHER Henry Buckingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Julia E Ellison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Mrs Emma Buckingham
(Address) 1714 Guilford ave

15 Filed MAY.13 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1921, to May 12, 1921, that I last saw h.im alive on May 12, 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Bronchi-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph T. Kemp, M. D.

. 19 (Address) 1800 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	May 14 1921
20 UNDERTAKER	ADDRESS
W M Routson	2258 N Milton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53696 — 42 — D 53696

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5202 Denmore St. 27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Estell Simpson

(a) RESIDENCE. No. 5202 Denmore St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 31 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Simpson

6 DATE OF BIRTH (month, day, and year) June 4, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife. 37

(b) General nature of industry, business, or establishment in which employed (or employer) Cooking - Washing

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Lancaster Co. Va.

PARENTS

10 NAME OF FATHER Llewellyn Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co. Va.

12 MAIDEN NAME OF MOTHER Fannie Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co. Va.

14 Informant Elizabeth Simpson
(Address) 5202 Denmore ave.

15 Filed MAY 13 1921, 19 ROBERT J. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1921, to May 11, 1921, that I last saw h. alive on May 11, 1921, and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) yrs. 8 mos. 7 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Rodman Baltimore

Was there an autopsy? No

What test confirmed diagnosis? Physical - Sledge.

(Signed) William J. Wright, M. D.

May 12, 1921 (Address) 1209 Freeman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	May 15 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Lemmon

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1476

79 D 53697

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C. Grose

(a) RESIDENCE. NO. 533 N. Hoffman St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nathaniel C. Grose

6 DATE OF BIRTH (month, day, and year): May 6th 1876

7 AGE: Years 45 | Months | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Matilda Bullett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Johns Hopkins Hospital

15 Filed: MAY 13 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21 1921 to May 10 1921 that I last saw h[illegible] alive on May 10 1921 and that death occurred, on the date stated above, at 2.50 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Paroxysmal tachycardia (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Electrocardiogram & Clinical findings

(Signed) Edward C. Davidson M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: May 13 1921

20 UNDERTAKER: Geo. R. Holland ADDRESS: 123 N. Grand Ave.

BUREAU OF VITAL STATISTICS

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-18—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

D 53698

CERTIFICATE OF DEATH.

REGISTERED NO. D 53698

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1961 N. Lexington ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte C. Stein

(a) RESIDENCE. NO. 1961 N. Lexington ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. E. Stein

6 DATE OF BIRTH (month, day, and year) Feb 13 - 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Michael

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm E. Stein Husband
(Address) 1961 N Lexington

15 Filed MAY 13 1921 19 ROBERT A. LEAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 10, 1921, that I last saw h.e alive on May 10, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy
(Cerebral Hemmorhage) 12 hrs
(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Walter E. Krieseman, M. D.

May 11 1921 (Address) 2002 N Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
J. B. Hilpert	May 14 1921
20 UNDERTAKER	ADDRESS
Western Cemetery	2336 Fred'k Ave

Should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPAmation should be properly classified, so that it may CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53699

HEALTH DEPARTMENT—CITY OF BALTIMORE.

45

D 53699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 22 Wheeler Ave ST.; 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Pamelia Zimmerman

(Residence in Baltimore: No. 22 Wheeler Ave St.; .....yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, July 2nd, 1918
(Month) (Day) (Year)

7-AGE, 2 yrs. 10 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Child

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm R. Zimmerman

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Anna B. Blank

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm R Zimmerman

(Address) 22 N Wheeler Ave

15-

Filed MAY 19 1921, 191.....

ROBERT B. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 26" 1920, to May 12" 1921, that I saw h[illegible] alive on May 11" 1921, and that death occurred, on the date stated above, at 5.40 a m.

The CAUSE OF DEATH* was as follows:

Cancer of right Orbit

..... (Duration) ....yrs. 4 mos. 16 ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs.....mos.....ds.

(Signed) C. N. Duvall M. D.

May 17, 1921 (Address) 1817 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL, May 14th, 1921

20-UNDERTAKER J. B. Hepburn

ADDRESS 2326 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53700

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 N. Carey St. 15 ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Joseph Smith

(Residence in Baltimore: No. 1323 N. Carey St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	Colrd	Single

6-DATE OF BIRTH, June (Month) 21 (Day), 1919 (Year)

7-AGE, 1 yrs. 10 mos. 21 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Jabez Smith

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co.

12-MAIDEN NAME OF MOTHER Kate Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Balto. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Kate Smith

(Address) 1323 N. Carey St

15-

Filed MAY 12 1921

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 (Month) 12 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 5-4-21 191..., to 5-11-21 191..., that I saw h[illegible] alive on ..., 21 191..., and that death occurred, on the date stated above, at 2.45 m.

The CAUSE OF DEATH* was as follows:

Whooping-Cough

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) malnutrition

..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Lee Cardozo M. D.

5-12-21, 191... (Address) 1524 N. Hill Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	MAY 13 1921
20-UNDERTAKER H. DENNIS	ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53701

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2311 E. Chase ST.; 8 WARD)

2-FULL NAME Samuel Kennard Reese

(a) RESIDENCE. NO. 2311 E. Chase St ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 5-1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Isaac Benesch.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Samuel.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Reeves.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore County (State or country)

14 Informant Robert Reese.
(Address) 1430 N. Chester St.

15 Filed MAY 13 1921 19.. BOWER & LAUTER Registrar

Burial or Removal Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 27 1921, to May 12, 1921, that I last saw h[illegible] alive on May 12, 1921, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum T.B. bacilli +++

(Signed) Louis A. Im Brune M. D.

, 19 (Address) 2500 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 16. 19..

20 UNDERTAKER William Cook — ADDRESS 5025 Harford Ave

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53702

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53702

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3813 Hamilton Ave ST.: West Arlington WARD)

REGISTERED NO. 254 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Brown

(a) RESIDENCE No. 3813 Hamilton Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of James M. Brown

6 DATE OF BIRTH (month, day, and year) Aug 12 - 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ax Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER J. Henson

11 BIRTHPLACE OF ~~FATHER~~ (city or town) (State or country) Boston

12 MAIDEN NAME OF MOTHER Susan Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Maggie Robert

(Address) 3813 Hamilton Ave

15 Filed MAY 13 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 1st, 1918, to May 13th, 1921, that I last saw h~~im~~ alive on May 12th, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows: Acute Dilitation of heart

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Asthma Sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed dingnosis? —

(Signed) A. C. Smith, M. D.

(Address) 4529 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	5-16 1921
20 UNDERTAKER	ADDRESS
Williams Court	502 E North Ave

Information should be carefully supplied. AGE should be stated EXACTLY. Literal answers to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Valvular Disease of the Heart

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53703

CERTIFICATE OF DEATH.

53 D 53703

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 S. Collington Ave. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME, Frank Koshinski

(Residence in Baltimore: No. 732 S. Collington Ave. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W.	—

6-DATE OF BIRTH, March 9 (Month) (Day), 1921 (Year)

7-AGE, ...yrs. 2 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....—
(b) General nature of industry, business, or establishment in which employed (or employer).....—

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Stanley Koshinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Josephine Sopko

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanley Koshinski

(Address) 732 S. Collington Ave

15-MAY 13 1921 [illegible] KRAUTER

Filed....., 191.... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/26/21 191..., to 5/13/21 191..., that I saw him alive on 5/12/21 191..., and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Splenic Myelogenous Leukemia

(Duration).....yrs.....mos. 2 1 ds.

CONTRIBUTORY (Secondary) none

(Duration).....yrs.....mos.....ds.

(Signed) D. J. Sussman M. D.

5-13-21, 191... (Address) 1419 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary Cem	May 15 ....., 191...
20-UNDERTAKER	ADDRESS
David Diamond	421 S. Bond St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Gruebel.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53704

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 53704

CERTIFICATE OF DEATH.

110

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter F. Gruebel

(a) RESIDENCE. NO. 1716 N. Stephen ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Gruebel

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Jewel designer artist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Emil Gruebel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ

12 MAIDEN NAME OF MOTHER Augusta Waddigen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Emil Gruebel

(Address) 319 N. Gilmor St

15 MAY 13 1921 [illegible] REGISTERED

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 13, 1921, that I last saw h.. alive on May 13, 1921, and that death occurred, on the date stated above, at 2:40 p.m.

The CAUSE OF DEATH* was as follows:

Pericardial Effusion

(duration) yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 9-'21

Was there on autopsy?

What test confirmed diagnosis?

(Signed) Wm S Gerin M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	May 16 1921
20 UNDERTAKER	ADDRESS
Chas E. Tomich	80 Madison Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53705

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53705

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 Fawcett ST.; 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry L Hurner Jr

(a) RESIDENCE. No. 410 Fawcett ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apl 2 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry L Hurner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER May Russel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry L Hurner (Address)

15 Filed MAY 13 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 2 1921 to May 13 1921 that I last saw him alive on May 12 1921 and that death occurred, on the date stated above, at 130A m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration)* yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Prematurely born.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Alexander Randall M. D.

5/12 1921 (Address) 846 W 36 & 87.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	May 14 1921

20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut Ave

MAY 13 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53706

CERTIFICATE OF DEATH.

1791-89

D 53706

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 W Preston ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Wright

(a) RESIDENCE. No. 512 W Preston ST., WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Col-	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 13- 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none Old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md-

PARENTS

10 NAME OF FATHER Wm Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md-

12 MAIDEN NAME OF MOTHER Eliza Spencer-

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Wm Wright- father
(Address) 512 W Preston St-

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Vol 31921 Burial Permit Card

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May- 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 12- 1921, to May 13- 1921, that I last saw her alive on May 11- at 1921, and that death occurred, on the date stated above, at 5-a- m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? Her home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Chest Examination

(Signed) Samuel A Bonn, M. D.

, 19 (Address) 937 Madeira Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 14 1921
20 UNDERTAKER Daniel Eagan	ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53707

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53707

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: No. 26 ST. WARD) 79-91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dollie Dixon

(a) RESIDENCE. NO..... ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE: Years 68 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hospital Balto, Md.

15 Filed Robert P. Harrison, Registrar

d 31921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1918 to May 11, 1921

that I last saw h... alive on May 11, 1921

and that death occurred, on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) H. Goldsmith, M. D.

5/13/21 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 13' 21
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Eu

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53708 ✓ X 122 D 53708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

REGISTERED NO.....

CITY OF BALTIMORE: (No. Fort McHenryBaltimore Md. ST.: N WARD) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Baker

(a) RESIDENCE. NO. US. Public Health Hosp. #56 Fort McHenry ST., WARD. Baltimore Md.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
~~mle~~ male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electric worker

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Mr Willaim F Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Edgar T. Rowbottom Registrar. US. Public Health Hosp. #56

15 Filed 19 Robert F. Harrison, Registrar

MAY 13 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from March 15 1921, to May 12 1921

that I last saw him alive on May 12 1921.

and that death occurred, on the date stated above, at 4'15 p.m.

The CAUSE OF DEATH* was as follows:

Cyst of kidney, sinus left kidney

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation preeede death? yes Date of May, 12 1921

Was there an autopsy? No

What test confirmed diagnosis? Exam. clinic report

(Signed) Thomas R Payne

5/13 1921 (Address) Senior Surgeon (R) P.H.S. US. P.H.S. Hosp. #56 Ft. Mc Henry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wheeling W. Va — DATE OF BURIAL May 13. 1921

20 UNDERTAKER S. Levinson & Bro — ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53709 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53709

42

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N Duncan ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magalnie Gajan

(a) RESIDENCE. No. 706 N Duncan ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow John Gajan

6 DATE OF BIRTH (month, day, and year) May 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Gajan (Address) 706 N Duncan St

15 Filed Robert P. Harrison, Registrar

MAY 13 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 19 19 21 to May 10 19 21

that I last saw her alive on May 10 19 21

and that death occurred, on the date stated above, at 5 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
and Edema of the Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward L Cook M. D.

5/11, 1921 (Address) 413 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 14 1921
20 UNDERTAKER	ADDRESS
M Cook 512 E Pratt	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

142972 D 53710

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53710

CERTIFICATE OF DEATH.

8-91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Holland

(a) RESIDENCE. No. 111 Warren Ave St., Ward. Cambridge Mass.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Spencer Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ruth Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records.

15 Filed MAY 13 1921, 19 Robert [illegible]
Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10 , 1921, to May 13 , 1921, that I last saw h[illegible] alive on May 13 , 1921, and that death occurred, on the date stated above, at 4.00 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) W R Davison, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK Cem	MAY 14 1921
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST.

MAY 13 1921

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53711

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 ✓ D 53711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. N. W. Cor. Mount & Franklin sts 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Blaecher

(Residence in Baltimore: No. 3000 Arunah Ave. St.: 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	widower

6-DATE OF BIRTH, ... May ..., 1840
(Month) (Day) (Year)

7-AGE, 80 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... retired 186
(b) General nature of industry, business, or establishment in which employed (or employer) ..... tool making

9-BIRTHPLACE, (State or Country) Germany

PARENTS.

10-NAME OF FATHER, Mehrmann

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Blaecher Jr.

(Address) 3000 Arunah Ave.

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

MAY 14 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May 11, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) jury find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
(5 months)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. H. Hennessy M. D.
(Coroner.)

May 13, 1924 (Address) 2802 Eutaw Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

28-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, May 14th, 1924

20-UNDERTAKER A. Jones

ADDRESS 212 E. Biddle St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53712

CERTIFICATE OF DEATH.

X 28-610 D 53712

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 N Luzerne St. ST.; 7 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Morgan

(Residence in Baltimore: No. 512 N Luzerne St

St.; ....yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, April 11, 1870 (Month) (Day) (Year)

7-AGE, 50 yrs. 1 mos. 1 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mill Worker
(b) General nature of industry, business, or establishment in which employed (or employer): Mfg

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER George Morgan

11-BIRTHPLACE OF FATHER (State or Country) England

12-MAIDEN NAME OF MOTHER Sarah Ayers

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harold Rossen

(Address) 512 N. Luzerne

15-

Filed MAY 14 1921, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1920, to May 12 1921, that I saw him alive on May 10 1921, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Pleurisy (Tuberculosis of Lungs)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) La Grippe

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. J. Gibney M. D.

May 12, 1921. (Address) 777 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Steubenville Ohio

19-PLACE OF BURIAL OR REMOVAL, Steubenville Ohio | DATE OF BURIAL, May 14, 1921

20-UNDERTAKER William Cook | ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 53713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53713

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Kent & Toccoma Ave ST., 15 WARD)

2-FULL NAME Cornelius M. Newkirk

(a) RESIDENCE No. Kent & Toccoma ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced, (or) WIFE of Sarah Newkirk

6 DATE OF BIRTH (month, day, and year) Dec 22 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Glass Worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Clement Newkirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant (Address) Paul Newkirk Kent & Toccoma Ave

15 Filed ..... 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk

5/14/1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1921, to May 13, 1921, that I last saw him alive on May 12, 1921 and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) chronic interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Walter A Cot, M. D.

5/13, 1921 (Address) 841 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elmer N. Jersey	May 16 1921
20 UNDERTAKER	ADDRESS
Joseph Jeffries	Elmer North Ave

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53714

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 N Pulaski ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Lula Miller

(a) RESIDENCE. No. Near Owings Mills ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 18, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas Fredk Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliza Jane Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Florence A Merriam

(Address) 2104 N Pulaski St

15 Filed MAY 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to May 12, 1921, that I last saw her alive on May 11, 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard, M. D.

May 14, 1921 (Address) 42 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olive Cem	May 15 1921
20 UNDERTAKER	ADDRESS
Wm Fickus & Sons	North & Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53715 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53715

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 815 N. Chapel St., (Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. W. Couter

(a) RESIDENCE. No. 815 N. Chapel St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 48 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer): 059
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Andrew J. Couter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md.

12 MAIDEN NAME OF MOTHER: Sarah McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Edgar Couter
(Address): 815 N. Chapel St.

15 Filed 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 - 1921.

17 I HEREBY CERTIFY, That I attended deceased from March, 19 19, to May 12, 19 21, that I last saw him alive on May 12, 19 21, and that death occurred, on the date stated above, at 4 15 p. m.

The CAUSE OF DEATH* was as follows:

Emphysema over

Dilatation of Heart (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles B. A. Meyer M. D.

5/13, 19 21 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: May 16th 1921

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E. Monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous
Due to asthma

D 53716 HEALTH DEPARTMENT—CITY OF BALTIMORE 175-003 D 53716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Bryant

(Residence in Baltimore: No. 733 S. Broken St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, January 11, (Month) (Day) 1884 (Year)

7-AGE, 37 yrs. 4 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O.

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, R. Bryant

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Cath. Kramer

13-BIRTHPLACE OF MOTHER (State or Country), md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kath. Bryant

(Address) 733 S. Broken St.

15- Robert J. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

MAY 14 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12, (Month) (Day) 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

~~Fract. of skull~~ Fracture of skull and fracture of right clavicle. Caused by accidental fall from freight car.

Autopsy at funeral gives no cause for death - case upon Coroner's

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. Riley M. D. (Coroner.)

May 14, 1921 (Address) 16 E. Lex.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Some days

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel Cemetery	May 16, 1921.
20-UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Flat St

S.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53717 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53717

CERTIFICATE OF DEATH. 151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 N. Fulton ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Dobbins

(a) RESIDENCE. NO. 1914 N. Fulton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal.	Colrd.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
-	1921	May	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Emery Dobbins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana.

12 MAIDEN NAME OF MOTHER Abigel Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emery Dobbins
(Address) 1914 N Fulton Ave

15 Filed May 14 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1921, to May 13, 1921, that I last saw him alive on May 13, 1921, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Prematur.
Birth chart.
6½ mo. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. B. Cullen M. D.

6/14/21 (Address) 2735 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	May 14, 1921
20 UNDERTAKER Joseph Syfer	ADDRESS 160 W. Pratt ave

MAY 14 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53718

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Henrietta Hecht.

(a) RESIDENCE. No. 5003 Beaufort Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of William S. Hecht

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady & Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Fur Dept 066

(c) Name of employer Leon Simon

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Abraham Allgaier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Allgaier Wolfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edwin S Hecht

(Address) 5003 Beaufort Ave

15 MAY 14 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1921, to May 13, 1921, that I last saw her alive on May 13, 1921, and that death occurred, on the date stated above, at 12.27 a m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Acute Cardio Vascular Collapse (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Fred J Baumgartner, M. D.

5/13, 1921 (Address) Md. Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York N. Y.	May 15 1921
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	16 11 Read

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53719

D 53719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. Ward 18)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgiana Lardusky

(a) RESIDENCE. No. 847 W. Lexington St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert H. Lardusky.

6 DATE OF BIRTH (month, day, and year) June 19-1866

7 AGE: Years 54 | Months 10 | Days 24 | If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Washington D.C.

9 BIRTHPLACE (city or town) (State or country) ....

PARENTS

10 NAME OF FATHER George Small

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Eliza Grove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant A. H. Lardusky (Address) 847 W Lexington St

15 Filed MAY 14 1921, 19.... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1921, to May 13, 1921, that I last saw her alive on May 13, 1921, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Right Ovary

(duration) yrs. 9 mos. ? ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? Yes Date of May 12, 21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. F. Tompkins M. D.

19.... (Address) Maryland General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: May 16 1921

20 UNDERTAKER: Putnam & Sons — ADDRESS: 1723 W. Lafayette Ave

I.—WRITE PLAINLY, WITH UNFADING INK. All questions should be answered. If any information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 53720

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3217 E. Balto. ST.: 76 WARD)

2-FULL NAME Amelia W. Crisp

(a) RESIDENCE. No. 3217 E. Balto. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj F. Crisp

6 DATE OF BIRTH (month, day, and year) July 9, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Rosenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Benj F. Crisp
(Address) 3217 E. Balto. St.

15 Filed MAY 4 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/21

17 I HEREBY CERTIFY, That I attended deceased from March, 19 21 to May 11, 19 21, that I last saw h[illegible] alive on May 11 19 21, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Typical Exam

(Signed) J. C. Wade, M. D.

(Address) 143 N. Bway

5/12/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem. DATE OF BURIAL: May 15 1921

20 UNDERTAKER: Philip Sterz ADDRESS: 2016 Orleans St.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53721

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53721

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Memorial Hospital St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Letetia T. Walker

(a) RESIDENCE. No. Godfrey S. Carolina St. Ward. Gaffney S. C.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Sidney O. Walker

6 DATE OF BIRTH (month, day, and year) Sept 30, 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Chas. P. Petty

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina.

12 MAIDEN NAME OF MOTHER Cordelia Garratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant Mrs. J. H. Crews

(Address) Spartanburg S.C.

15 Filed MAY 14 1921 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1921, to May 13, 1921, that I last saw her alive on May 13, 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Godfrey, S.C.

Did an operation precede death? Yes. Date of April 28, 1921

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation

(Signed) George E. W. Hardy, M. D.

19 (Address) Mercy Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gaffney S.C.	May 14 1921

20 UNDERTAKER John Ottet Co. ADDRESS 1201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53722 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53722

CERTIFICATE OF DEATH. 164

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2314 E. Federal St. 8 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kenneth Neumayer

(Residence in Baltimore: No 2314 E. Federal St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Sgl

6-DATE OF BIRTH, Sept 14, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... NN
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, F. W. Neumayer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lillie V. Scott

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. W. Neumayer

(Address) 2314 E. Federal

15- Robert P. Harrison,

Filed....., 191.....

MAY 4 1921 Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoning by food.

Corned beef (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Mueller M. D.
(Coroner.)

5-14-21, 191.. (Address) 1 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	May 14, 1921
20-UNDERTAKER Jirkler & Jirkler	ADDRESS 1739 Eager

8—Every item of information should be carefully supplied. AGE should be filled in EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

147928 D 53723

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53723

CERTIFICATE OF DEATH.

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys V. Jolly

(a) RESIDENCE. No. 2325 E Federal St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20 - 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ~~DD~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Jolly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAY 14 1921, 19 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1921

17 I HEREBY CERTIFY, That I attended deceased from May 3rd, 1921, to May 14, 1921, that I last saw her alive on May 14, 1921, and that death occurred, on the date stated above, at 7:12 a m.

The CAUSE OF DEATH* was as follows:

Emphysema

OVER

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of May. 8th 1921

Was there an autopsy? no

What test confirmed diagnosis? X ray

(Signed) W R Garrison, M. D.

5-14, 1921 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	May 16 1921
20 UNDERTAKER Fickler & Zirkler	ADDRESS 1739 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 14 1921

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for empyema
which was due to
streptococcus demolyticus
Source of infection lobar
pneumonia.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53724 X 28 D 53724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp, #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 30 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barry Biss

(a) RESIDENCE. NO. US. Public Health Hosp. #56 ST. Fort McHenry Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
29	yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer: ---

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John H Biss.

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address) Edgar T. Rosebrough Registrar. US. PHS Hosp. #56 Ft McHenry Md.

15 Filed MAY 4 1921 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7 1921 to May 12 1921, that I last saw him alive on May 12 1921, and that death occurred, on the date stated above, at 925 a.m. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary far advanced active.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Exam clinic report

(Signed) Thomas R. Payne M. D.

5/13 1921 (Address) Senior Surgeon (R) US. PHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Marlboro Md	May 14 1921
20 UNDERTAKER	ADDRESS 1127
A. Leubuscher Bro Baltimore	

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53725

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2505 N. Bucknell ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esbit Alfreda Curtis

(a) RESIDENCE. No. 2505 N. Bucknell ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1920

7 AGE: Years | Months: 10 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Nathan A Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Rachael Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn

14 Informant Mrs Curtis
(Address) 2505 N Bucknell St

15 Filed MAY 14 1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1921, to May 13, 1921, that I last saw h[illegible] alive on May 13, 1921, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

MCN

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys

(Signed) J A Curry Gunn, M. D.

May 14, 1921 (Address) 1508 Bucknell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middletown Conn.

DATE OF BURIAL: 5-14 1921

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

c/o Nathan Curtis. - Via P.R.R.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 14 1921

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Baltimore Peterson

D 53726

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 53726

CERTIFICATE OF DEATH.

168-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1954 N. Patterson Pk Ave ST.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C Buchtel

(Residence in Baltimore: No. 1954 N. Patterson Pk Ave St.; yrs. 49 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ... January 26, 1861 (Month) (Day) (Year)

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home 037
(b) General nature of industry, business, or establishment in which employed (or employer): Wife

9-BIRTHPLACE, (State or Country), Cincinnati Ohio

PARENTS.

10-NAME OF FATHER, Henry Gehring Forst

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Margaret Weiler

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H Buchtel Bro

(Address) 1954 N. Patterson

15- MAY 14 1921 Filed ....., 191.....

Robert P. Harrison, Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Illuminating Gas

Accidental (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H C Smith M. D. (Coroner)

5-14-1921 (Address) M.E. Dept

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Back Cemetery Inc — DATE OF BURIAL, May 16 1921

20-UNDERTAKER Robt J Turner — ADDRESS 1424 N Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53727

CERTIFICATE OF DEATH.

40 D 53727

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 E. Pratt ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Winks

(a) RESIDENCE. No. 519 E. Pratt St ST., 1 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Winks

6 DATE OF BIRTH (month, day, and year) March 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Winks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Cleary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lena Winks (Address) 519 E Pratt St

15 Filed MAY 14 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1921, to May 12, 1921, that I last saw h— alive on May 12, 1921, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) A L Lord, M. D.

5-13, 1921 (Address) 270 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 16, 1921
20 UNDERTAKER Robt J Turner Inc	ADDRESS 1424 Pine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53728

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 53728

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 Riversidean St.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Joseph Feeney

(a) RESIDENCE. No. 1039 Riversidean ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sabina Feeney

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	1	9	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Yard foreman

(b) General nature of industry, business, or establishment in which employed (or employer) G. B. S. Brewing Co

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER William Feeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Feeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Sabina Feeney. (Address) 1039 Riverside ave.

15 Filed MAY 14 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1921, to May 12, 1921, that I last saw him alive on May 12, 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urine

(Signed) Wm. E. Stiles, M. D.

5/13 1921 (Address) 1319 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cem	5/16 1921
20 UNDERTAKER	ADDRESS
John J. Fahey & Sons.	1818 Light

AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53729

CERTIFICATE OF DEATH.

X 109 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE (No. U. P. D. ST.: 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laurence E. McCullough

(Residence in Baltimore: No. Freelands, Md. St.; yrs., mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Mar 27, (Month) (Day) 1906 (Year)

7-AGE,	If LESS than 1 day,
15 yrs. 1 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Wm C. McCullough

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Rosa Cole

13-BIRTHPLACE OF MOTHER (State or Couutry), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm C. McCullough

(Address).....

15- Robert P. Harrison,

Filed MAY 14 1921, 191..... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Intestinal Intussusception (cecal)

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

May 14, 1921 (Address) 280 S. Eden Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death U. P. D. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Freeland, Md.

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel	May 16, 1921
20-UNDERTAKER E. L. Stiffler	ADDRESS 125 E North Ave

MAY 14 1921

8.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. NATIVITY should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53730

HEALTH DEPARTMENT—CITY OF BALTIMORE

28

D 53730

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Cross

(a) RESIDENCE. NO. 1835 Kavanaugh st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Cross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Raymore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to May 12, 1921, that I last saw him alive on May 11, 1921, and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. Etzgey, M. D.

5-12-21, 19 (Address) Municipal Tuc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union Bethel Church Cem'y Randallstown	May 15 19 21

20 UNDERTAKER Geo. Groff Hooper ADDRESS 406 N. Conway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53731

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 53731

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 Harrison ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola Ruth Hiser.

(Residence in Baltimore: No. 203 Harrison St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) baby.

6-DATE OF BIRTH, May 11, 1921.
(Month) (Day) (Year)

7-AGE, — yrs. 2 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work baby (?)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Howard E. Hiser

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Viola R. Miller

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard E. Hiser

(Address) 203 Harrison

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MAY 14 1921

B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 11 1921, to May 13 1921, that I saw her alive on May 12 1921, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Malnutrition and Premature birth 2 months gestation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) failure of kidneys

Uremia

(Duration) ....yrs. ....mos. ....ds.

(Signed) Charles E. Clarke M. D.

May 13, 1921. (Address) 1306 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, May 14, 1921.

20-UNDERTAKER George H. Schwab — ADDRESS 510 Park Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53732

D 53732

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH US Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson Berry 1027 W Lexington St

(a) RESIDENCE. No. US. Public Health Hosp. #56 ST., Fort McHenry Baltimore Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	~~married~~ married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Wilson Berry

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59 yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work seaman

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ----

086

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T Rambaske Registrar (Address) US. PHS Hosp. #56 Ft McHenry Md

15 Filed MAY 14 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12/21 19

17 I HEREBY CERTIFY, That I attended deceased from April 28 19 21 to May 12 1921 19, that I last saw h alive on May 12 1921 19, and that death occurred, on the date stated above, at 10'40A. M. m.

The CAUSE OF DEATH* was as follows:

Gengrene right foot & leg.

ONN

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of May 12 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas B. Paynes M. D.

, 19 (Address) Senior Surgeon (R) USPHS Hosp. #56 Ft McHenry Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 15 1921
20 UNDERTAKER John H. Loadenwiedel	ADDRESS 142

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman.* (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Senile gangrene
operation for gangrene.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53733 D 53733

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 22 WARD)

REGISTERED NO. 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Conway

(a) RESIDENCE. No. 432 W. Henrietta St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lonnie Bellian

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed MAY 19 1921 Robert P. Harrison, Registrar
(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1921 to May 13, 1921.
that I last saw him alive on May 13, 1921.
and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X ray examination

(Signed) V B Eidman, M. D.

5/13/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 17 1921
20 UNDERTAKER	ADDRESS 142
John H. Trader	Ustick St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

145073

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53734

120

D 53734

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Spuggs.

(a) RESIDENCE. No. 1216 Division St. Balto Md ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Black	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ida Spuggs.

6 DATE OF BIRTH (month, day, and year) Dec 17th ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James F. Spriggs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Pindell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Blands.

15 Filed ..... 19 ..... Registrar

Robert P. ~~Harrison~~

Burial Permit Clerk.

14 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10 1921 to May 13 1921, that I last saw h~~im~~ alive on May 13 1921, and that death occurred, on the date stated above, at 9½ a m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Urinary Findings

(Signed) Edward C. Davidson M. D.

5/13. 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	May 16 1921
20 UNDERTAKER John H. Soadin	ADDRESS 142 W Lee St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53735

CERTIFICATE OF DEATH.

147 3/14 31

D 53735

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 15 WARD)

2-FULL NAME Katherine Alton

(a) RESIDENCE. NO. 1114 Presstman St WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Willie Starks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jenna Alton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 MAY 15 1921 BOARD OF HEALTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4 1921, to May 13, 1921.

that I last saw her alive on May 13, 1921.

and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous pentonitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. Louison, M. D.

May 13, 1921 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: May 16 1921

20 UNDERTAKER: Edw. Ruggold

ADDRESS: 1463 Carey

D 53736

Spec.—6-9-19—H. P. Co.—1000 Blks.

53736 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53736

CERTIFICATE OF DEATH. 64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 N Milton Ave ST.) 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard C Wilhelm

(a) RESIDENCE. NO. 624 N Milton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise M Wilhelm

6 DATE OF BIRTH (month, day, and year) Jan 29 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schloss Bros

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Louise M Wilhelm
(Address) 624 N Milton Ave.

15 MAY 15 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-12-21, 19..., to 5-13-21, 19..., that I last saw h ~~live~~ on 5-13-21, 19..., and that death occurred, on the date stated above, at 1209 m.

The CAUSE OF DEATH* was as follows:

Apoplexy 7½ hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Seymour M. D.

May 13 1921 (Address) 3586 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Mem	May 16 1921

20 UNDERTAKER ADDRESS

Wm Cook & Nattans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.– 1000 Blks.

53737 HEALTH DEPARTMENT—CITY OF BALTIMORE 53737

D 53737 CERTIFICATE OF DEATH. 79 D 53737

1-PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 1802 Dulaney St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. McGrath

(a) RESIDENCE. No. 1802 Dulaney WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah B. McGrath

6 DATE OF BIRTH (month, day, and year): aug 1845.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 000
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS
10 NAME OF FATHER: Mark McGrath
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Bridget Donahue
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Robert Thomas
(Address): 1802 Dulaney

15 Filed MAY 15 1921 ROBERT J. BRAUTIGAM Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 13, 1921, that I last saw h. alive on May 13, 1921, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Wallace, M. D.

(Address) 2757 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	5-16 1921

20 UNDERTAKER: William Coale — ADDRESS: 502 E. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53738 53738 ✓ 91 53736 D 53738

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Groundh Ave ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elba G. Mowbray

(a) RESIDENCE. No. 519 Groundh Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alexander Mowbray

6 DATE OF BIRTH (month, day, and year) Oct. 2-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Isaac Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah M. Coy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Alexander Mowbray
(Address) 519 Groundh Ave

15 Filed MAY 15 1921 ROBERT A. LAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1921

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1921, to May 14, 1921,

that I last saw h alive on May 14, 1921,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Bronchs

(duration) yrs. mon. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Wm J Walsh, M. D.

May 14 1921 (Address) 2124 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	May 17 1921
20 UNDERTAKER Wm Cook	ADDRESS 1131 E. N. Ave

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Chase

D 53739

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 D 53739

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 School St. ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Chase

(a) RESIDENCE. No. 721 School ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
30	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co.

PARENTS

10 NAME OF FATHER: Zach Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co

12 MAIDEN NAME OF MOTHER: Barbara Jacks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co

14 Informant: Barbara Chase

(Address): 721 School St

15 Filed MAY 15 1921 19... ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/12 1921

17 I HEREBY CERTIFY, That I attended deceased from 5/11, 1921, to 5/12, 1921, that I last saw h.e alive on 5/12, 1921, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

Bloody dysentery (duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) ....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Burkett, M. D.

, 19 (Address) City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pinkney Cemetery	May 15 1921
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53740

CERTIFICATE OF DEATH.

79 D 53740

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N. Gilmor ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward. W washington

(Residence in Baltimore: No. 520 N. Gilmor St att St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	blk	married

6-DATE OF BIRTH, ... Autumn ....., 1 ..... (Month) (Day) (Year)

7-AGE, 51 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 04

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thaomas Washington

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Susan Curry

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... George Washington

(Address) 520 Gilmor St

15- MAY 15 1921 ROBERT P. LAZZETTI

Filed....., 191.... Burial ..... Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... may ..... 12 ....., 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from may 9th 1921, to may 12th 1921, that I saw him alive on may 11th 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
Hypertrophy Valvular lesion
probably
(Duration) 1 yrs. 5 mos. 2 ds.

CONTRIBUTORY (Secondary) Heart as Uremia
probably
(Duration) 1 yrs. 2 mos. 5 ds.

(Signed) R. T. E. Lancaster M. D.

may 12th, 1921. (Address) 1811 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, May 15, 1921

20-UNDERTAKER Edward Pueggold — ADDRESS 1463 Carey

N. B.—Every item of information should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 53741

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53741

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST.: 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irvin Herling

(Residence in Baltimore: No. 2908 Keyworth ave St.; .....yrs., 7 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Single

6-DATE OF BIRTH, Nov — 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 7 mos.....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md Balto City

PARENTS.

10-NAME OF FATHER. Mr Herling

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Gutman

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levis

(Address) 1411 E Baltimore

15- MAY 15 1921 ROBERT F. [illegible]
Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12th 1921, to May 14 1921, that I saw h[illegible] alive on May 14 1921, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Empyema and obstruction
to respiration

(Duration).....yrs.....mos...3...ds.

CONTRIBUTORY.....
(Secondary)

[redacted] (Duration).....yrs.....mos...15...ds.

(Signed)...[signature]...M. D.

5-17-21 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 7 ds. In the State .....yrs. 7 mos.....ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 2908 Keyworth ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Friendship	5/17, 191..

20-UNDERTAKER Jack Levis ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Duct Lobar pneumonia. Re infection prior

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53742

CERTIFICATE OF DEATH.

109 D 53742

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 3[illegible]th WARD)

2-FULL NAME Cornelius Lynch

(a) RESIDENCE. No. West Grove Pa ST., ... WARD. (West Grove - Pa)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred not 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single -

6 DATE OF BIRTH (month, day, and year) 1874 (Nov 2)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
~~Mth 74~~	46	6	17	years

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Farm Work

(c) Name of employer [illegible]

9 BIRTHPLACE (city or town) (State or country) West Grove Pa

PARENTS

10 NAME OF FATHER Cornelius Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland -

14 Informant John J Lynch - (Brother)

(Address) West Grove - Pa.

15 Filed MAY 15 1921 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct ..... 1920, to May 14 ..... 1921, that I last saw him alive on May 13th ..... 1921, and that death occurred, on the date stated above, at 5-20 A. m.

The CAUSE OF DEATH* was as follows:

Intussusception of the Bowels -

(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Mania

(duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Mt Hope & West Grove Pa

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

May 14th, 1921 (Address) Frank J Flannery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Grove - Chester Co Pa — DATE OF BURIAL May 18 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

MAIL should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53743

CERTIFICATE OF DEATH.

D 53743

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4004 Park Heights av ST.; 15 WARD)

REGISTERED NO. C 1

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen M. Thompson

(Residence in Baltimore: No. 4004 Park Heights av St.; 40 yrs., mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May (Month) 8 (Day), 1881 (Year)

7-AGE, 40 yrs. mos. 5 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Music 068

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry S. Thompson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ella L. Tridell

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella C. Thompson

(Address) 4004 Park Heights Ave

15- MAY 15 1921

Filed ....., 191.... ROBT. J. KLAUS

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 13 (Day); 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 26 1921, to May 13. 1921, that I saw her alive on May 13. 1921, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

(Signed) James S. Ashurst M. D.

May 14 1921. (Address) 4012 Park Heights ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, May 16, 1921

20-UNDERTAKER A. V. Marshall ADDRESS 3539 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53744

42 D 53744

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 S. Kenwood Ave. WARD 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine A. Wittig

(a) RESIDENCE. No. 509 S. Kenwood Ave WARD 1
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John H. Wittig.

6 DATE OF BIRTH (month, day, and year) Nov. 27th 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Riddle

11 BIRTHPLACE OF FATHER (city or town) Kentuckey
(State or country)

12 MAIDEN NAME OF MOTHER Mary. —— Wyatt

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. Md.
(State or country)

14 Informant John H. Wittig
(Address) 509 S. Kenwood Ave.

15 Filed MAY 15 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 11th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to May 11, 1921, that I last saw her alive on May 10, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: Uterine Cancer (Cancer)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Yes

(Signed) J. Wallenstein, M. D.

(Address) 1 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cemetery	May 15 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 4033 E. Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 53745

HEALTH DEPARTMENT—CITY OF BALTIMORE

109 D 53745

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 861 W Franklin, St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathan Wiggins

(Residence in Baltimore: No. 861 W Franklin St.; 0 yrs., 4 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, December 26, 1920
(Month) (Day) (Year)

7-AGE, 4 yrs. 4 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John Jackson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lizzie Wiggins

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Jackson

(Address) 861 W Franklin

15- ACCEPTED [illegible]

MAY 15 1921 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 13, 1921, to May 14 1921, that I saw h[illegible] alive on May 14 1921, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Strangulation Hernia

(Duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) None

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) R. B. Kennedy M. D.

May 14, 1921 (Address) 609 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, May 15, 1921

20-UNDERTAKER James H. Dennis ADDRESS 1303 Prestman St.

CAUSE OF DEATH must be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53746

CERTIFICATE OF DEATH.

120 D 53746

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Garutzuk

(a) RESIDENCE. No. 527 S. Washington St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER Joe Garutzuk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Hospital Records
(Address): New City Hospital.

15 MAY 15 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1921, to May 13, 1921, that I last saw him alive on May 12, 1921, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood chemical tests

(Signed) B Herman, M. D.

5/13/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	May 16 1921

20 UNDERTAKER: John A Weber ADDRESS: 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D 53747

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 Bevans ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Teresa Fannon

(Residence in Baltimore: No. 923 Bevans St.: 2 yrs., 5 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	

6-DATE OF BIRTH, November (Month) 17 (Day), 1918 (Year)

7-AGE, 2 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Fannon

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Ross

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Fannon

(Address) 923 Bevans Street

15- MAY 15 1921

Filed....., 191.....

BOARD OF HEALTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 7 1921, to May 14 1921, that I saw her alive on May 14 1921, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Alan S. Rothbart M. D.

May 14, 1921. (Address) 210 E. Baltimore Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state: (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross, A. & C. Cy. DATE OF BURIAL, May 16, 1921.

20-UNDERTAKER William Cook ADDRESS 502 E. N. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53748

CERTIFICATE OF DEATH.

D 53748

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Green & Lombard St.: Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nick D. Solon

(a) RESIDENCE. No. 236 Walnut St. Morgantown W. Va. Ward. Morgantown W Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurateur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant B. D. Solon (Address) Morgantown W. Va.

15 Filed MAY 15 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-12, 1921, to 5-13, 1921, that I last saw h alive on 5-12, 1921, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis and

Chronic Diffuse Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. P. Handley, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 16 1921
20 UNDERTAKER	ADDRESS
Harry N. Witzke	1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53749

CERTIFICATE OF DEATH.

79 D 53749

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4101 Kate St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D. Maguigan

(a) RESIDENCE. No. 4101 Kate St. ST., WARD. Phila Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: John C Maguigan

6 DATE OF BIRTH (month, day, and year): Aug 10 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia

PARENTS

10 NAME OF FATHER: Ebr Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Philadelphia

12 MAIDEN NAME OF MOTHER: Mary Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Philadelphia

14 Informant: William E McCabe

(Address): 4101 Kate St

15 Filed MAY 15 1921 ROBERT I. LEADER Registrar

Burial permit Oleo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/15 1921

17

I HEREBY CERTIFY, That I attended deceased from Oct, 1920, to May, 1921, that I last saw her alive on May 15 1921, and that death occurred, on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows:

myocarditis, arterio Sclerosis.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. G. Tuten, M. D.

, 19 (Address) 3501 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia — DATE OF BURIAL: 5-16 1921

20 UNDERTAKER: William Cook — ADDRESS: 507 E North

MAJOR should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

144 883 D 53750
53750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

53750 X31 D 53750

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Kate Bagwell.

(a) RESIDENCE. NO. Forest Park South St. Carolina WARD. Honea Path S.C.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student - Nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER John Bagwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C

12 MAIDEN NAME OF MOTHER Mrs Nannie Bagwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C

14 Informant (Address) Johns Hopkin Hospital Records

15 Filed MAY 16 1921 ROBERT R. CARTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1920, to May 15, 1921, that I last saw h[illegible] alive on May 15, 1921, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis - tuberculous?
Septicemia -
Pulmonary abscesses.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) - none -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia S. Carolina

Did an operation precede death? yes. Date of Dec. 12 1920

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy

5-15-21 (Signed) L. R. Wharton M. D.

5-15-21 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenville S.C.

DATE OF BURIAL May 15 1921

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 N Broad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No active pulmonary T.B.
Streptococcus aureus.

Spec.—6-9-19—H. P. Co.—1000 Bks.

53751 D 53751

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53751 91 53751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Glyndon ave ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Sullivan

(a) RESIDENCE. No. 1305 Glyndon ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. T. Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Hume

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Alice Sullivan
(Address) 1305 Glyndon ave

15 MAY 16 1921 ROBERT J. LAMUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1921, to May 14, 1921, that I last saw h.. alive on May 14, 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green M. D.

5-15, 1921 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leakesville Greene Co. Miss. Prince William Co. Va.

DATE OF BURIAL: May 16th 1921

20 UNDERTAKER: John. J. Gowan & Son

ADDRESS: 901 Hollins St.

MAKE ENTRIES WITH PEN AND INK. PENCIL WILL NOT COPY. NAME should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1711

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 53752

CERTIFICATE OF DEATH

1 PLACE OF DEATH — Registered No. C 19 D 53752

CITY OF BALTIMORE (No. 4106 Ridgewood ave St. 15 Ward)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ferdinand Bernheimer

(Residence in Baltimore: No. 4106 Ridgewood ave St.: 68 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: April 4 (Month), 4 (Day), 1855 (Year)

7 AGE: 66 yrs. 1 mos. 10 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Dept Store

9 BIRTHPLACE (State or country): Hartford Conn

PARENTS

10 NAME OF FATHER: Abraham Bernheimer

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mathilde Kohn

(Address) 4106 Ridgewood Ave

15 MAY 16 1921 Filed ....., 19.. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 14 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May, 1910, to May 14 1921, that I saw h-im alive on May 13 1921, and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. 2 mos. ds

Contributory (SECONDARY): Nephritis

(Duration) yrs. mos. 14 ds.

(Signed) A. Samuels M. D.

May 14, 1921 (Address) 1928 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Ohel Shalom Cem — DATE OF BURIAL: May 16, 1921

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 1611 Madison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Acute deaths. No further history if any abnormal condition

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationory fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinol fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sorcoma,* etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Haemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscorriage,*	*Pyaemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicaemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

53753

HEALTH DEPARTMENT—CITY OF BALTIMORE

137 D 53753

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West End Maternity Hospital

CITY OF BALTIMORE: (No. 12 N Calhoun St ST. 24 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah A. B Jory

(Residence in Baltimore: No. 1043 Compton St St.; 33 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 21, 1887 (Month) (Day) (Year)

7-AGE, 33 yrs. 9 mos. 22 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Patrick Hyland

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephen Jory (Husband)

(Address) 1043 Compton St

15-

MAY 16 1921, 191. [illegible] Registrar.

Buried in Mt Olivet Cem

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 7th 1921, to May 13th 1921, that I saw her alive on May 13th 1921, and that death occurred, on the date stated above, at 9 25 Pm

The CAUSE OF DEATH* was as follows:

Principal Sepsis
Following Child birth
(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Difficult labor
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry B Coll M. D.

May 16, 1921 (Address) 1703 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem | DATE OF BURIAL, May 17 1921

20-UNDERTAKER W. C. Doyle | ADDRESS 15 E. Lee St

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CAUSE OF DEATH must be plainly written, as it may be important. See instructions on back of certificate. OCCUPATION is very

Amendo

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53754

CERTIFICATE OF DEATH.

15 | 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Thames ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Ameodo

(a) RESIDENCE. NO. 1630 Thames ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balty
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Ameodo

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Spain

12 MAIDEN NAME OF MOTHER Theresa Ameodo

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Spain

14 Informant Joseph Ameodo
(Address) 1630 Thames St

15 Filed MAY 16 1921 19 ROBERT I. BAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1921, to May 14, 1921, that I last saw h. alive on May 14, 1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Degen & symptoms

(Signed) Thos A. Smithson, M. D.

(Address) 1623 E. Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	May 16 1921
20 UNDERTAKER H. Sander & Sons	ADDRESS 1710 Fleet St

mation should be carefully supplied. Any information may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53755

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 S. Bond ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospitnl or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Panzer

(a) RESIDENCE. No. 608 S. Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 5 1897

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
23	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER George F. Panzer

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Anna Pfister

13 BIRTHPLACE OF MOTHER (city or town) Ger.
(State or country)

14 Informant Mrs. Anna Panzer
(Address) 608 S. Bond st.

15 Filed MAY 15 1921 BOYER & LAUTER Registrar

Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1921

17

I HEREBY CERTIFY, That I attended deceased from April 4 1921, to May 14 1921,

that I last saw him alive on May 13 1921,

and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous Enteritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary TB

(duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there nn autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. F. Fiss, M. D.

May 15, 1921 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	May 17 1921

20 UNDERTAKER ADDRESS

Jos. J. Mew 156 N. Luzerne ave.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53756

CERTIFICATE OF DEATH.

120 D 53756

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 Reistertown Rd ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Goodwin Sr.

(a) RESIDENCE. NO. 2310 Reistertown Rd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angela Goodwin

6 DATE OF BIRTH (month, day, and year) Sept 22-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sovereign Grand

(b) General nature of industry, business, or establishment in which employed (or employer) Secretary of

(c) Name of employer I. O. O. F.

9 BIRTHPLACE (city or town) (State or country) Cobb Co. Ga.

PARENTS

10 NAME OF FATHER Williamson H. Goodwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Lucinda Pryor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Mrs. E. L. Goodwin. (Address) 2310 Reistertown Rd.

15 Filed MAY 16 1921 ROBERT F. LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 1920, to May 12, 1921, that I last saw h— alive on May 11, 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema, [redacted] Pericarditis and Mitral insufficiency.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis & Arterio Sclerosis (duration) 0 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard S. French M. D.

5/17/1921 (Address) 1707 Eamewood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL May 16 1921

20 UNDERTAKER Joseph B Cook ADDRESS 603 N Bals St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53757 ✓ 120 D 53757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S. Stricker ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ellen King

(a) RESIDENCE. No. 410 S. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Benj. King

6 DATE OF BIRTH (month, day, and year) Aug. 31st., 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) South River
(State or country) Md.

PARENTS

10 NAME OF FATHER Dennis Purdy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Miss Jacobs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Miss Lilly I. King
(Address) 410 S. Stricker St

15 Filed MAY 16 1921 ROBERT A. KRAUTZ Registrar
Burial Permit Oleft

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 14" 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to May 14 1921,
that I last saw h-e alive on May 14 1921,
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Lula Lois Talbot, M. D.

5 15 1921 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May. 17" 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53758

D 53758

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 S. Pulaski St. ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl William Kraushaar

(a) RESIDENCE. NO. 601 S. Pulaski St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30th 1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Kraushaar

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mamie Hickey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mamie E. Kraushaar
(Address) 601 S. Pulaski St.

15 FILED MAY 16 1921 Robert A. Knabel Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 14, 1921, that I last saw h[e] alive on May 14, 1921, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pleuritic Effusion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A. Weis, M. D.

, 19 (Address) 1117 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 16th 1921

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to a broncho pneumonia with no history of any prior infection

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53759

CERTIFICATE OF DEATH.

151 D 53759

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hilldale ST.: 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Margaret Simmons

(a) RESIDENCE. NO. Hilldale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1 day	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (DD)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Hilldale (State or country)

PARENTS

10 NAME OF FATHER Buford A Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha M Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Martha M. Simmons (Address) Hilldale

15 FILED MAY 16 1921 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 14th 1921, to May 15th 1921, that I last saw h[illegible] alive on May 14th 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth - 8 months

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Twin

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. C. Smith, M. D.

(Address) 4509 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine.	May 16 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E. Hoffman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53760

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N. CARROLTON AVE ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME SARAH C. HUGHES

(a) RESIDENCE. NO. 722 N Carrollton ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	WIDOW

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of WM F. HUGHES

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) "

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) unknown

14 Informant Robt Brooks
(Address) 173 Calhoun st

15 Filed MAY 16 1921 19 ROBERT P. KRAUTZ Registrar
Chief Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1921

17 I HEREBY CERTIFY, That I attended deceased from May 12th, 1921, to May 12, 1921, that I last saw h er alive on May 12, 1921, and that death occurred, on the date stated above, at 11 P. ....m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

.....

.....(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY —
(Secondary)
.....(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Glassman, M. D.

May 15 1921 (Address) 2682 Westwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
DRUID RIDGE CEM	MON 5/16 1921
20 UNDERTAKER ROBERT T. BROOKS & SON	ADDRESS 173 CALHOUN ST

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53761 X74 D 53761

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST. 46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flos Foster

(a) RESIDENCE. NO. Colgate Creek ST.... WARD. 9/a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Marian Foster

6 DATE OF BIRTH (month, day, and year) Oct 2 1881

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mathews Co Va

PARENTS

10 NAME OF FATHER Jas Foster

11 BIRTHPLACE OF FATHER (city or town) Mathews (State or country) Co Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Marian Foster. Colgate Creek.

15 Filed MAY 16 1921 ROBERT E. LEAUTE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/1921

17

I HEREBY CERTIFY, That I attended deceased from 4/20/ 1921, to 5/14/ 1921,

that I last saw him alive on 5/14/21 1921,

and that death occurred, on the date stated above, at 8:10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Basic Cause

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? C.M. findings & Symptoms

(Signed) Chas A Denman M. D.

, 19 (Address) 5 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	May 17 1921
20 UNDERTAKER Robert Brockerson	ADDRESS

THIS is very important. See instructions on BACK OF CERTIFICATE.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

(Dr Rivers at St Joseph's Hosp.
No history of any traumatism. J
Brain tumor. Degenerated cystic glioma of Rt lobe of cerebellum.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53762

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 S. Bouldin ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Hedl

(a) RESIDENCE. NO. 137 S. Bouldin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 17-1920

7 AGE — Years: — Months: 1 Days: 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Alfred Hedl

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Delia Gillen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Alfred Hedl

(Address): 137 S. Bouldin St.

15 Filed: MAY 16 1921 ROBERT B. BRADFORD Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/13 19 21.

17 I HEREBY CERTIFY, That I attended deceased from May 12, 19 21., to May 13, 19 21.; that I last saw her alive on May 13, 19 21., and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions 1

8 (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? N Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. H. Mengel Jr., M. D.

(Address) N 38 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: 5-16 19 21

20 UNDERTAKER: J. J. Moran ADDRESS 300 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53763

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64

D 53763

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2009 Penrose Ave ST 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lenhart Lotz.

(Residence in Baltimore: No. 2009 Penrose. St.; 2 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6-DATE OF BIRTH: May (Month) 20 (Day), 1852 (Year)

7-AGE: 68 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Cementer
(b) General nature of industry, business, or establishment in which employed (or employer): 083

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Unk

11-BIRTHPLACE OF FATHER (State or country): Unk

12-MAIDEN NAME OF MOTHER: Unk

13-BIRTHPLACE OF MOTHER (State or country): Unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Lotz.

(Address) 2009 Penrose Ave

15. Filed MAY 16 1921 19.. MONEY & CLAUSEN Burial Permit filed. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 14 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1920, to May 14 1921, that I saw him alive on May 13, 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) 1 yrs. — mos. — ds

Contributory (SECONDARY) Arteria Sclerosis

(Duration) 5 yrs. mos. ds.

(Signed) Marshall B West M. D.

May 14, 1921 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. — mos. — ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: May 16 1921

20-UNDERTAKER: C. F. McCormick — ADDRESS: 1931-33 Pratt St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53764

CERTIFICATE OF DEATH.

79 D 53764

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hebrew aged Home ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Isaacson

(a) RESIDENCE. NO. 111-115 Wiegmuth street WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victor Isaacson

6 DATE OF BIRTH (month, day, and year) July 6 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Edward Isaacson

(Address) Haddock Pa

15 MAY 16 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1921, to May 15, 1921, that I last saw her alive on May 15, 1921, and that death occurred, on the date stated above, at 12 30 p m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

6

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Baylin, M. D.

5/17, 1921 (Address) 210 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	5/16 1921
20 UNDERTAKER Jack Levin	ADDRESS 1411 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 1921765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

*161 ✓ 53765

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter ward Riley.

(a) RESIDENCE. No. Graham N.C. Alamance Co. Box 312 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 0 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8. 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Graham N.C.

PARENTS

10 NAME OF FATHER Walter ward Riley.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Orange Co. N.C.

12 MAIDEN NAME OF MOTHER Susan Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Alamance Co. N.C.

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed MAY 16 1921 19 ROBERT E KRAUT Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17 I HEREBY CERTIFY, That I attended deceased from May 5 1921, to May 15 1921, that I last saw him alive on May 15 1921, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis - (Chronic)
Organism not grown -

(duration) yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary): None —

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Graham NC —

Did an operation precede death? Yes - Date of May 12th 21

Was there an autopsy? Yes -

What test confirmed diagnosis? Operation

(Signed) Mont R Reid, M. D.

5-15-21, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Graham N. C.	May 16 1921
20 UNDERTAKER	ADDRESS
William G. Schaefer	1800 Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53766

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53766

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore Genl. Hospital

CITY OF BALTIMORE: (No. 1213 Light St.) (WARD 24)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny Bell Bisser

(a) RESIDENCE: No. 315 E Hamburg ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of John A Bisser

6 DATE OF BIRTH (month, day, and year) Nov 15 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Baltimore Ind

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard Sparkes

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Emily Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

11 Informant John A Bisser
(Address) 315 E Hamburg St

15 Filed MAY 16 1921 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14- 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-11- 1921, to 5-14- 1921,
that I last saw her alive on 5-14- 1921,
and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Polyp of uterus

(duration ... yrs. 6 mos. ... ds.)

CONTRIBUTORY (Secondary) Hemorrhage Secondary Anemia

(duration ... yrs. 2 mos. ... ds.)

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 5-13-21

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Howard D Jolson, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: CEDAR HILL. DATE OF BURIAL: MAY 17 1921

20 UNDERTAKER: JOHN F. DENNY ADDRESS: 716 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53767

CERTIFICATE OF DEATH.

152 D 53767

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Myers

(a) RESIDENCE. No. 1621 N. Spring Av. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	Infant		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Leroy Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Myrtle ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. Leroy Myers 1621 N. Spring St.

15 Filed MAY 16 1921 19 ROBERT B. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1921, to May 14, 1921, that I last saw him alive on May 14, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Infantile Hemorrhage (baby had been bleeding from gastro intestinal tract Since birth

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. Craig (RMW), M. D.

5/14, 1921 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bath Cem	May 16 1921
20 UNDERTAKER	ADDRESS
J. Herring & Co	2008 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53768

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53768

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 N. Castle ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A. H. Loehr

(a) RESIDENCE. No. 227 N Castle ST., ...WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of ~~(or WIFE of)~~ Magdelena Loehr

6 DATE OF BIRTH (month, day, and year) Aug 16-48

7 AGE — Years: 72 Months: 9 Days: 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: I Hamburger Sons

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Magdelena Loehr
(Address) 227 N. Castle

15 Filed MAY 16 1921 19 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 19 1920 to May 13 1921 that I last saw h[illegible] alive on May 11 1921 and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Arteriosclerosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) General Anasarca

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. J. Gehry, M. D.

5/14. 1921 (Address) 627 N Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mathews	May 16 1921
20 UNDERTAKER Philip Henig	ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53769

CERTIFICATE OF DEATH.

79 D 53769

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1621 Milliman ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob C. Henkel

(a) RESIDENCE. NO. 1621 Milliman ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~WIFE~~ HUSBAND of Mary E. Henkel

6 DATE OF BIRTH (month, day, and year) Nov 7.-50

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Henkel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E. Henkel

(Address) 1621 Milliman

15 Filed MAY 16 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17

I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1920, to May 15 1920, that I last saw him alive on May 12 1920, and that death occurred, on the date stated above, at 9-30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J Schmidt, M. D.

, 19 (Address) 701 Ilkenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk	May 18 1921
20 UNDERTAKER Philip Herrig	ADDRESS 2016 Aliceano

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53770 ✓ D 53770

CERTIFICATE OF DEATH.

96

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1118 Somerset ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Lehr

(a) RESIDENCE. No. 1118 Somerset ST., 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Nicholas Conrad Lehr

6 DATE OF BIRTH (month, day, and year) March 18 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Rosa Gutherlet
(Address) 1131 Harford Ave

15 Filed MAY 16 1921 JOHN E. KRAUL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th 1921

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to May 15, 1921, that I last saw her alive on May 14, 20, 1921, and that death occurred, on the date stated above, at 6 20 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) yrs. 11 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L. Passano, M. D.

May 15-1921 (Address) 2314 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[redacted] Cemetery	May 17 1921
20 UNDERTAKER	ADDRESS
Henry Hoech & Son	1311 E. Eager St
Baltimore County.	

information should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epid[illegible] cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous. No history of any organic heart trouble of any.

Probably acute dilatation of heart.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 5 7.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-53771

D 53771

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1012 N. Broadway ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella L. Kenney

(a) RESIDENCE. No. 1012 N Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 1st 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Daniel Kenney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Leahey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Katie Kenney
(Address) 1012 N Broadway

15 Filed MAY 16 1921 ROBERT J. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1921

17 I HEREBY CERTIFY, That I attended deceased from —, 19 20, to May 14, 19 21, that I last saw h.. alive on May 14, 19 ..., and that death occurred, on the date stated above, at 8 10 a m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Wallis O White Jr. M. D.

5/14, 19 21 (Address) 2800 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 17 1921
20 UNDERTAKER	ADDRESS
Henry Horsch Son	1301 E Eager St

N. B.—... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53772

1-PLACE OF DEATH — REGISTERED No. C 172

CITY OF BALTIMORE (No. 2452 Greenmount Ave St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert H. Leese

(Residence in Baltimore: No. 2452 Greenmount Ave St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 14 (Day), 1857 (Year)

7-AGE, 64 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Surgical
(b) General nature of industry, business, or establishment in which employed (or employer) Instrument Maker

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mullord P. Leese

(Address) 712 N. Arlington Ave

15- Filed MAY 16 1921, 191 ROBT. P. KRAUTZ Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to H.K. death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries received from falling down Stairs Fractured Neck.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas Knowles M. D. (Coroner.)

May 16, 1921 (Address) 7692 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, May 17, 1921.

20-UNDERTAKER Henry Hoerle Sons — ADDRESS 1301 E Eager St

Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53773

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53773

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1312 N. Spring ST.; 9 (WARD)

2-FULL NAME Lucille Williams

(a) RESIDENCE. No. 1312 N. Spring ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred N yrs. — mos. — ds. How long in U. S., if of foreign birth? life yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or —min.
	18 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co, Va
Live in Baltimore 18

PARENTS

10 NAME OF FATHER Isaac Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co, Va.

12 MAIDEN NAME OF MOTHER Emma Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co, Va

14 Informant Lucy F. Taylor
(Address) 1532 N. Dallas St.

15 Filed MAY 16 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 14 May 1921

17 I HEREBY CERTIFY, That I attended deceased from 12 May, 1921, to 14 May, 1921, that I last saw her alive on 13 May, 1921, and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

General (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) General exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I don't Know.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) Winfield Boyd, M. D.

(Address) 1710 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 16 1921
20 UNDERTAKER Mrs R A Elliott.	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

147960 D 53774

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53774

CERTIFICATE OF DEATH. + 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Singleton.

(a) RESIDENCE. No. 834 Rutland Av Balto Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

Florida

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ ~~WIFE of~~ Rosa Burgess sister Same address

6 DATE OF BIRTH (month, day, and year) June 25 - 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 040

(b) General nature of industry, business, or establishment in which employed (or employer) Porter

(c) Name of employer

live in Balt one week

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Jerry Singleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Maggie Hurth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAY 16 1921 ROBERT I. KRAFT Registrar

Deputy Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 13, 1921, that I last saw h~~im~~ alive on May 13, 1921, and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows:

Gastric hemorrhage.

(duration) ... yrs. ... mos. ... dys.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological findings

(Signed) Edward C Davidson M. D.

5/23, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mrs R A Elliott	May 16 1921
20 UNDERTAKER	ADDRESS 1725 Ashland
Int American Cem	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53775

CERTIFICATE OF DEATH.

42

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1646 E. Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Howard

(Residence in Baltimore: No. 1646 E. Monument St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, June 9, 1863
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
57 yrs. 11 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 37

9-BIRTHPLACE, (State or Country), Born in Harford Co Md Lives in Baltimore 40 years

PARENTS.

10-NAME OF FATHER, Joshua Buchanan

11-BIRTHPLACE OF FATHER (State or Country), York Pa

12-MAIDEN NAME OF MOTHER Elizabeth Ann Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie M. Conaway

(Address) 1646 E. Monument St

15- MAY 16 1921 REGISTRAR'S DISTRICT

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1920, to May 13 1921, that I saw her alive on May 12 1921, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Epithelioma of uterus 6

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Adolph C. Eisenbrey M. D.

May 15, 1921 (Address) 2201 O'Donnell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	May 17, 1921
20-UNDERTAKER	ADDRESS
Wm R A Elliott	1725 Aisquith St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53776

CERTIFICATE OF DEATH.

D 53776

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 Eagon St — ST.; 7 WARD)

2-FULL NAME Helena W. Connery.

(a) RESIDENCE. No. 1835 Eagon St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widogle

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Connery.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Boston Mass

14 Informant: George McCabe
(Address) 1835 Eagon St.

15 FILED MAY 16 1921 BOARD OF HEALTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1921, to May 15, 1921, that I last saw h— alive on May 14, 1921, and that death occurred, on the date stated above, at 7 15 m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism
Chr Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Richards, M. D.

19 (Address) 215 Hutchins ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 16th 1921
20 UNDERTAKER: John J Lowan & Son	ADDRESS: 901 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53777

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

91 D 53777

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Wilmer alley ST.; 17 WARD)

2-FULL NAME Douglas Mantell Ross

(a) RESIDENCE. No. 1102 Wilmer alley ST.; ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Eugene Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eugene Ross

(Address) 1102 Wilmer alley

15 Filed MAY 16 1921 19 ROBERT A. CRAWFORD Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14-1921

17 I HEREBY CERTIFY, That I attended deceased from 5-12-, 1921, to 5-14-, 1921, that I last saw him alive on 5-14-, 1921, and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

0000

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jos. H. Borgill, M. D.

5-15-1921 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 18 21

20 UNDERTAKER George H. Holland ADDRESS 1631 Division Hilgrove

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection

Spec. 6-9-19—H. P. Co.—1000 Bks.

D-53778

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92-079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kaufman

(a) RESIDENCE. (Usual place of abode) No. Allegheny City, Pa. ST., WARD. Allegheny City Pa

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse dealer 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Allegheny City Pa

PARENTS

10 NAME OF FATHER Peter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Rein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record

(Address)

15 Filed MAY 16 1921 [illegible] Registrar

Burial Permit Olor

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1921

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1921, to May 14, 1921, that I last saw h. me alive on May 14, 1921, and that death occurred, on the date stated above, at 11.15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Francis I. Feeney, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carro De Grace Md	5/16 21
20 UNDERTAKER	ADDRESS
George A Farley	Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D-53779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-53779

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Roberts ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patience Watkins

(a) RESIDENCE. No. 503 Robert ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14 1868

7 AGE 53 Years 4 Months Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Bucky Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Eliza Tinsley
(Address) 406 Cathedral

15 FILED MAY 16 1921 ROBERT J. BRYDEN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14-1921

17 I HEREBY CERTIFY, That I attended deceased from May 13th 1921, to May 14, 1921, that I last saw h[illegible] alive on May 14th, 1921, and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ? 23 Wenbover Rd Guilford

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) D Frank Bott, M. D.

19 (Address) 3654 N Bradley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cmty — DATE OF BURIAL: May 17 1921

20 UNDERTAKER: George H. Holland — ADDRESS: 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53780

HEALTH DEPARTMENT—CITY OF BALTIMORE.

42

D 53780 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1818 Belt St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances E. Lotman

(a) RESIDENCE. No. 1818 Belt St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 7 mos. 10 ds. How long in U. S., If of foreign birth? 25 yrs. 7 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Lotman

6 DATE OF BIRTH (month, day, and year) Oct 5 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Shields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER J. Wachwicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Harry Lotman (Address) 1818 Belt St

15 MAY 16 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 1919, to May 15, 1921, that I last saw h[illegible] alive on May 14, 1921, and that death occurred, on the date stated above, at 8-[illegible] m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. E. Campbell M. D.

M[illegible] 1921 (Address) 1244 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	5/17 1921
20 UNDERTAKER	ADDRESS
D. Frew McCully	1301 E. Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53781 ✓ × 109 D 53781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Franklin Square Hospital St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Columbus Thompson

(a) RESIDENCE. No. Landsdowne Md St., WARD. Lansdowne Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Effie Thompson

6 DATE OF BIRTH (month, day, and year) May 20, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Road Supervisor Howard Co. 086

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer State of Maryland

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Columbus Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Effie Thompson Lansdowne Md.

MAY 16 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1921

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1921, to May 14, 1921, that I last saw h. / M. alive on May 12, 1921, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) yrs. mos. 4 ds. ?

CONTRIBUTORY (Secondary) Intestinal obstruction with gangrenous bowel

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 12, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lymon S. Abbott, M. D.

19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. View Gens. Howard Co.	May 17. 1921
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

A. B.—THIS IS A PERMANENT RECORD, AND ENTRIES MADE HEREON should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53782

D 53782

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clement Robinson

(a) RESIDENCE. No. 627 Stirling st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Louisiana

PARENTS

10 NAME OF FATHER Marion Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records (Address) M.T.H.

15 Filed MAY 16 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1921, to May 11, 1921, that I last saw him alive on May 10, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. J. Rigney, M. D.

5-11-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND. DATE OF BURIAL 19

20 UNDERTAKER ADDRESS MAY 16 1921

MARK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53783

CERTIFICATE OF DEATH.

19 D 53783

REGISTERED NO.....

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Baltimore Md ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Waldrop

(a) RESIDENCE. No. 808 E. Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John Waldrop

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Elizabeth [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Husband (Address) Mercy Hospital

15 Filed MAY 16 1921 ROBERT B KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 25, 1921, to May 11, 1921, that I last saw h[illegible] alive on May 11, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis L. Kearney, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS MAY 16 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53784 1120 — 151 D 53784

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 N Madison ave St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bryan Walford

(Residence in Baltimore: No. 1120 ~~2011~~ Madison ave St.; ....yrs.,....mos....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~; (Write the word.)

6-DATE OF BIRTH, May 15th, 1921 (Month) (Day) (Year)

7-AGE, 4 hours. ....yrs....mos....ds.

If LESS than 1 day, 4 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 1120 ~~2011~~ Madison ave Balto.

PARENTS.

10-NAME OF FATHER, Roy B. Walford.

11-BIRTHPLACE OF FATHER (State or Country), Rio W. Va.

12-MAIDEN NAME OF MOTHER Ethel Bodkorenz

13-BIRTHPLACE OF MOTHER (State or Country), Rio W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ~~Father~~ Pauline Bon

(Address) 1120 Madison Ave

15- Filed MAY 16 1921, 191.... ROBERT A. LEVY Registrar

Burial Permit ...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1921, to May 15 1921, that I saw him alive on May 15th 1921, and that death occurred, on the date stated above, at 5.17 p.m.

The CAUSE OF DEATH* was as follows:

Premature Child.

4 hours.
(Duration) ....yrs....mos....ds.

CONTRIBUTORY.....
(Secondary)
(Duration) ....yrs....mos....ds.

(Signed) Frank S. Hundley M. D.

....., 191... (Address) 2502 Mary Land Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL. DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health. ADDRESS MAY 16 1921

Per. Wm. E. WOODALL

J862

Spec.—6-9-19—H. F. Co.—1000 Blks.

D 53785

HEALTH DEPARTMENT--CITY OF BALTIMORE

151 D 53785

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2549 Frederick ave ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Gertrude & Scott Smith

(a) RESIDENCE. NO. 2549 Frederick Ave. 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years Months Days — If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Scott E Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Gertrude Bosley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Gertrude Smith
(Address) 2549 Frederick ave

15 Filed MAY 16 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to ..., 19..., that I last saw h. alive on May 15, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Asa L Wolssels, M. D.

, 19 (Address) 2865 Frederick ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westonmeitz	May 18 21
20 UNDERTAKER	ADDRESS
Geo L Schmatt & Bro	[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A FEDERAL AS WELL AS A STATE RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53786

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53786

CERTIFICATE OF DEATH.

104-091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S. Highland Ave ST.: 26 WARD)

2-FULL NAME Rita A. Hachn

(a) RESIDENCE. No. 410 S. Highland Ave ST., 26 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1 - 1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Hachn

11 BIRTHPLACE OF FATHER (city or town) Balto Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Agatha Ditz

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant (Address) John Hachn 410 S. Highland Ave

15 Filed MAY 16 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1921, to May 15, 1921, that I last saw her alive on May 15, 1921, and that death occurred, on the date stated above, at 5.40 a. m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) H. B. Tilson, M. D.

5-16, 1921 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	May 19 1921
20 UNDERTAKER Lilly & Zeile	ADDRESS 403 S. Mos... St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53787

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53787

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital (ST.) 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry B. Fisheren

(a) RESIDENCE. NO. 502 W. Robinson ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19- 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Corkmaker.

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John M. Fisheren

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Leisch

13 BIRTHPLACE OF MOTHER (city or town) Indiana (State or country)

14 Informant Elizabeth Fisheren (Address) 502 N. Robinson St

15 Filed MAY 16 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1921, to May 14, 1921, that I last saw him alive on May 14, 1921, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	May 17 1921
20 UNDERTAKER Lilly and Feiler	ADDRESS 4038 Wolfe

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE CLEARLY, WITH UNFADING INK—THIS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic nephritis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53788

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53788

CERTIFICATE OF DEATH

82

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.; 14 WARD)

2-FULL NAME Kate Hoebett.

(a) RESIDENCE. No. 638. Mosher ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6yr yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Harry Douglas Richmond

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md DC.

12 MAIDEN NAME OF MOTHER Ellen Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md DC.

14 Informant (Address) Bay View Hospital Baltimore, Md.

15 Filed MAY 16 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1921

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1917, to May 15, 1921

that I last saw her alive on May 14, 1921 3:30 a.m.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Goldsmith M. D.

5/15 1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 17 1921
20 UNDERTAKER	ADDRESS
Saml R. Chase Son	1480 Mosher

MAY 16 1921

MATION.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53789

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53789

154

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 So. Bradford St.: I. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME KATHARINE PRZYBYLSKA,

(a) RESIDENCE. NO. 602 So. Bradford ST., I. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 27 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Widow,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ignaci Przybylski,

6 DATE OF BIRTH (month, day, and year) Nov-25- 1827,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	94	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Naklo, Posen

(State or country) Poland,

PARENTS

10 NAME OF FATHER Andrew Jagodrzenski,

11 BIRTHPLACE OF FATHER (city or town)

(State or country) POland,

12 MAIDEN NAME OF MOTHER Katharine **********

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland,

14 Informant John Cichy, Son-in-law,

(Address) 602 So. Bradford Street

15 Filed MAY 18 1921, 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 15 1921 19

17 I HEREBY CERTIFY, That I attended deceased from May 14, 19.., to May 15, 19 21.

that I last saw h alive on May 15, 19 21,

and that death occurred, on the date stated above, at 7.00 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.	May 17 1921
20 UNDERTAKER	ADDRESS
M. F. Sudowski.	705 S. Ann

B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53790 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 53790

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Eastern Ave ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michalina Szymonska

(a) RESIDENCE. No. 2203 Eastern Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 40 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 10-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Canning

(b) General nature of industry, business, or establishment in which employed (or employer) Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Joseph Szymonski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Narowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Francis Szymonski

(Address) 2237 Eastern Ave.

15 Filed MAY 16 1921, 19 Robert F. Harrison, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from February 28th 1921, to May 9th 1921, that I last saw her alive on May 9th 1921, and that death occurred, on the date stated above, at 11.20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory test

(Signed) Amelia E. Linke, M. D.

, 19 (Address) 1712 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.	May 18" 1921
20 UNDERTAKER	ADDRESS
M F. Sadowski.	705 S. Ann

MAY 16 1921

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53791 D 53791

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2035 N.Calvert Street ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Atkinson

(a) RESIDENCE. No. 2035 N.Calvert Street ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Augusta Atkinson

6 DATE OF BIRTH (month, day, and year) May 15-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	*	*	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Accountant

(c) Name of employer Jones-Lamb & Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thos.C.Atkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabella Croxall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Thos.C.Atkinson (Address) 2035 N.Calvert St.

15 Filed Robert P. Harrison, Registrar

MAY 16 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th. 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1921, to May 15. 21, that I last saw him alive on May 15. 21, and that death occurred, on the date stated above, at 8.39 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Failure of the heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Exam

(Signed) Wm H Pearce M. D.

May 16 1921 (Address) 2105 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Thomas Com. Garrison Forrest	May 17 1921
20 UNDERTAKER	ADDRESS
Chas. F. EVANS & SON	118 W. Mt Royal Av.

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53792

CERTIFICATE OF DEATH.

D 53792

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Ramsay ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Amburg

(Residence in Baltimore: No. 1508 Ramsay St.; Life yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. December 21, 1842 (Month) (Day) (Year)

7-AGE. 78 yrs. 4 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Grubb

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sarah Lightner

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. E. Amburg

(Address) 317 N. Parrish

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MAY 16 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16th, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 27 1921, to May 16th 1921, that I saw her alive on May 15th 1921, and that death occurred, on the date stated above, at 7.45 A.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation.

(Duration) yrs. 1 mos. ds.

(Signed) C. J. Nuckols M. D.

May 16th 1921 (Address) 130 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, May 18, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53793

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53793

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 W Cross ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Walter

(a) RESIDENCE. NO. 1126 W Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of Sophia Walter

6 DATE OF BIRTH (month, day, and year) Nov 28 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Walter

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

11 Informant Mrs Sophia Walter (Address) 1126 W Cross St

12 Filed MAY 18 1921, 19.. Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15 1921, 19.., to May 15 1921, 19.., that I last saw him alive on May 15 1921, and that death occurred, on the date stated above, at 5 59 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J H Schwensberg M. D.

, 19 (Address) 1120 W Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 17 1921
20 UNDERTAKER	ADDRESS
Wm J Pickus & Sons	Norfolk Va

IS A PERMANENT RECORD. Every line must be filled in. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS

Spec.—8-24-14—M. & T.—2000 Bks.

D 53794

HEALTH DEPARTMENT—CITY OF BALTIMORE

47

D 53794

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701-E-22nd St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Streett.

(Residence in Baltimore: No. 701-E-22nd St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, December 28, 1838 (Month) (Day) (Year)

7-AGE, 82 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 0.0

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas Bay

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Asenith Ann McClure

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis T. Streett.

(Address) 1224-E-North Ave

15-

Filed ....., 191.... Registrar.

Robert P. Harrison,

MAY 6 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 19 1917, to May 14 1921, that I saw h[illegible] alive on May 13 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) yrs. mos. ds.

(Signed) M. D.

....., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem — DATE OF BURIAL, May 17, 1921

20-UNDERTAKER Wm J Heckrotte & Sons — ADDRESS Norfolk Va

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53795 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 644 W. Mulberry St. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leroy Emmels

(Residence in Baltimore: No. 644 W Mulberry St.; yrs., — mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, ... March 29 1900
(Month) (Day) (Year)

7-AGE, 21 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), (Md.) Dorchester Co. Md

PARENTS.

10-NAME OF FATHER, Mark Emmels

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriett Barsley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Williams

(Address) 644 W Mulberry St

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

MAY 16 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May ..... 14 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

5-21-, 1921 (Address) 117 W Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Taylor's Island Md.

19-PLACE OF BURIAL OR REMOVAL, Taylor's Island Co. Dorchester Co. Md. DATE OF BURIAL, May 19. 21

20-UNDERTAKER Samuel A. Hensley ADDRESS 578 W Biddle St

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2212 E. Monument St.: 1 WARD)

2-FULL NAME Carl Edmonson

(a) RESIDENCE. No. 2212 E. Monument ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1st 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Carl Edmonson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Edmonson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carl Edmonson
(Address)

15 Filed MAY 16 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1921, to May 15, 1921, that I last saw h[illegible] alive on May 15, 1921, and that death occurred, on the date stated above, at 1.40 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb S. Hiter, M. D.

, 19 (Address) 1008 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mar. Cathedral	May 18 1921
20 UNDERTAKER	ADDRESS
Wendell Lippe & Son	372 Lund St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infectious disease prior.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53797

CERTIFICATE OF DEATH.

37 D 53797

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N Chapel ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Titus Koelbel

(a) RESIDENCE. NO. 224 N Chapel ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Koelbel

6 DATE OF BIRTH (month, day, and year) Dec 28 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66.	6.	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Wolfinger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant
(Address)

15 Filed MAY 16 1921 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1913. to May 16 1921
that I last saw him alive on May 15. 1921.
and that death occurred, on the date stated above, at 4 1/2 m.

The CAUSE OF DEATH* was as follows:

Loco-motor Ataxia

(duration) 8 yrs. mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Paralysis vesic

(Signed) Geo. Heller M. D.

5/16 19 21 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druby Redeemer Cemp	May 19 1921
20 UNDERTAKER	ADDRESS
Wendell & Purnell & Son	37 Lamb

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 16 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

147 831
D 53798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53798

CERTIFICATE OF DEATH.

X80

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M. Mathews.

(a) RESIDENCE. No. 2e Mrs. Oscar Wolff Eccleston ST., Balto. Co. Md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Hall (Campbell) 514 McElderry ST.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener 886

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Os Wolf

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Foreman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAY 17 1921 ROBERT F. BAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1921, to May 15, 1921, that I last saw h alive on May 15, 1921, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows: Myocardial Degeneration

CONTRIBUTORY (Secondary) Angina Pectoris (duration) yrs. 3 mos. ds.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological findings

(Signed) Edward C. Davidson M. D.

5/21 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dandy Spring Md

DATE OF BURIAL 5/17/21

20 UNDERTAKER Geo H Owens

ADDRESS 538 Dolphin St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53799

CERTIFICATE OF DEATH.

47 D 53799

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 E. Mulberry st ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mills Brooks

(a) RESIDENCE. NO. 111 E. Mulberry ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7- 1910.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Mills Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Fanie Burgess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mills Brooks
(Address) 111 E. Mulberry St

15 Filed MAY 17 1921 19 ROBERT F. SLAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15 1921

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 21, to May 15, 1921, that I last saw him alive on May 14, 1921, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Inf Pneumonia Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. H. Grinnalds, M. D.

5.16.1921 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	May 18 1921
20 UNDERTAKER	ADDRESS
Felix B. Pye	102 E Mulberry St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior as far as history could be obtained

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53800

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 125 S. Schroeder ST.; 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve E. Morris

(a) RESIDENCE. No. 125 S Schroeder ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Febry 5 - 1901

7 AGE	Years	Months	Days,	If LESS than 1 day, ...hrs. or ....min.
	20	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Martin Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McGlone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary Morris

(Address) 125 Schroeder St-

15 Filed MAY 17 1921 BOARD OF HEALTH

Registrar

Burial ... Cem.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1921

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to May 14, 1921, that I last saw h- alive on May 14, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Alcoholism & Heart

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward Blankenbuhler M. D.

May 17 1921 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 18th 1921
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hollins St-

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53801

CERTIFICATE OF DEATH.

D 53801

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N. Duncan ST.: 6 WARD)

2-FULL NAME Rose Crist

(a) RESIDENCE. No. 217 N. Duncan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of ~~HUSBAND of~~ Geo. Crist

6 DATE OF BIRTH (month, day, and year) Nov 26-98

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Isadore Griger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Frank Crist
(Address) 217 N. Duncan

15 MAY 17 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1921

17 I HEREBY CERTIFY, That I attended deceased from ... 19.. to May 14 1921, that I last saw h.. alive on May 14 1921, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Dilation (duration) ... yrs. 9 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Rosenau, M. D.

5/16/21, 19.. (Address) 801 N. Hammond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 18 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

NAME—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53802

D 53802

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Sinclair

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER William Sinclair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) Hospital Records, New City Hospital.

MAY 17 1921

ROBERT J. KRAMER
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1921 to May 14, 1921 that I last saw h... alive on May 14, 1921 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) ... yrs. ... mos. 5 ds.?

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) B Herman, M. D.

5/16/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: May 19/21

20 UNDERTAKER: John D. Spence ADDRESS: 325 N. Caroline

NOTE.—WHITE PAPER. WRITE WITH PEN AND INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53803

CERTIFICATE OF DEATH.

28 D 53803

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St.: 11 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Asbury Gregory

(a) RESIDENCE. No. 823 Druid Hill Ave. St., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 087

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.T.H.

15 Filed MAY 17 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1921, to May 14, 1921, that I last saw him alive on May 14, 1921, and that death occurred, on the date stated above, at 10.10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) L. J. Cheney, M. D.

5-14-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Laurel Cemetery May 17 1921

20 UNDERTAKER — ADDRESS

Mrs Geo H Hoover 406 W Camden

IMPORTANT. This certificate should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53804

CERTIFICATE OF DEATH.

91 D 53804

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 215 S Wolfe ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolores M Nowakowski

(a) RESIDENCE. No. 215 S Wolfe ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5/c yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Elex Nowakowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Martha Wisniewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Elex Nowakowski

(Address) 215 S Wolfe St

MAY 17 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1921

17

I HEREBY CERTIFY, That I attended deceased from May 14th 1921, to May 16th 1921, that I last saw her alive on May 15th 1921, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs.

(Signed) Amelia E. Light, M. D.

, 19 (Address) 1717 N Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	May (2) 1921
20 UNDERTAKER	ADDRESS
John M Weber	1203 Bond

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assc.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.
Was premature
baby.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 53805

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Baby) Wolf

(a) RESIDENCE. NO. 40 N. Edgar ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 21 hours How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 21 hrs. or — min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Isadore Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hanna Abidon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant J.O. Gamble M.D.
(Address) Johns Hopkins Hospital

15 Filed MAY 17 1921, 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to May 16, 1921, that I last saw h.im alive on May 16, 1921, and that death occurred, on the date stated above, at 4.40 a m.

The CAUSE OF DEATH* was as follows:

Prematurity (8 months)

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Guy N. Cromwell, M. D.

May 17 1921 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bklyn Cemetery Co	May 17 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53806

CERTIFICATE OF DEATH.

120 D 53806

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Fremont Ave ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Murray.

(a) RESIDENCE. No. 508 N. Fremont Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph T. Murray.

6 DATE OF BIRTH (month, day, and year) Feby 10th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Andrew Frish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Platzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Florence Phillips

(Address) 508 N. Fremont Ave.

15 MAY 17 1921 [redacted] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 7th, 1921, to May 15th, 1921, that I last saw h[illegible] alive on May 15th, 1921, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Krauger, M. D.

, 19 (Address) 1002 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 19, 1921
20 UNDERTAKER	ADDRESS
George J. Smith	1000 W. Fayette St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53807

D 53807

37

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2302 Division ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Johnson

(a) RESIDENCE. No. 2302 Division ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Bird Johnson

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Work 10

(b) General nature of industry, business, or establishment in which employed (or employer) House cleaning

(c) Name of employer washing & ironing

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Warren Herbert

11 BIRTHPLACE OF FATHER (city or town) Harrisburg (State or country) Pa

12 MAIDEN NAME OF MOTHER Jennie Herbert

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Sophie Griffin (Address) 2312 Division St

15 MAY 17 1921 ROBERT F. LEAUTEY Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1921

17

I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 15, 1921, that I last saw her alive on May 14, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: over

Valvular Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. William Frey, M. D.

5/16, 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 18 1921
20 UNDERTAKER Edward Ruggold	ADDRESS 1462 Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably due to lues.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53803 — 28 — 53803

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 47 Poca & Mt Auburn ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie Williams

(Residence in Baltimore: No. 47 Poca Mt Auburn St.; yrs., 30 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, unknown (Month), 1 (Day), ... (Year)

7-AGE, 47 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Hagerstown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Williams

(Address) 47 Poca St

15- MAY 17 1921, 191..... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage (Duration) suddenly yrs. ..... mos. ..... ds.

(Signed) James M Fenlon M. D. (Coroner.)

May 16th, 1921. (Address) 700 E Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	May 17, 1921
20-UNDERTAKER	ADDRESS
Edw. Ruggold	1463 Carey St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53809

CERTIFICATE OF DEATH.

X 28 D 53809

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1614 Greatman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Alton

(Residence in Baltimore: No. 1614 Greatman St.: yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, June 1, 1914
(Month) (Day) (Year)

7-AGE, 6 yrs. 11 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John W. Alton

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annie Terry

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. W. Alton

(Address) 1614 Greatman St.

15- FILED MAY 17 1921 BOARD OF HEALTH (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. T. Hennessy M. D.
(Coroner.)

May 16, 1921 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	May 17, 1921

20-UNDERTAKER Edw. Ruggold ADDRESS 1463 Carey St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53810 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53810

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mersity Hospital St. 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie M. Grissmer

(Residence in Baltimore: No. 844 St Peters St

St.; 20 yrs, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August (Month) 16 (Day), 1879 (Year)

7-AGE, 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Hagerstown Md

PARENTS.

10-NAME OF FATHER, Mr D Frysle

11-BIRTHPLACE OF FATHER (State or Country), Hagerstown Md

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Pittsburg Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo A Grissmer

(Address) 844 St Peters St

15-

Filed ..... 19.. Robert P. Harrison, Registrar.

MAY 17 1921 Burial Permit Clerk.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 16 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) Four hours

CONTRIBUTORY (Secondary) Dont Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch M. D. (Coroner.)

May 17, 1921. (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, London Park Cem — DATE OF BURIAL, May 19, 1921

20-UNDERTAKER Geo Limbach & Son — ADDRESS 647 W Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53811

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lawson

(a) RESIDENCE. No. 837 Hollins ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 13, 1921

7 AGE — Years — Months — Days — If LESS than 1 day, 10 hrs. or 5 min.

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER George Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Fannie Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant R. Riddall

(Address)

15 Filed MAY 17 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 13 1921

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1921, to May 13, 1921, that I last saw h.im alive on May 13, 1921, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) Guy H. Cromwell, M. D.

5/13, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 17 1921

For Wm. T. Wood Commissioner Health.

MAY 17 1921

MAY should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53812

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53812

CERTIFICATE OF DEATH.

X 6-091

8

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 N Wolfe ST.; WARD)

2-FULL NAME J. William Krebs

(a) RESIDENCE. NO. 1520 N Wolfe ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28/1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington Del.

PARENTS

10 NAME OF FATHER Charles H Krebs

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Anna M Lindenmuth

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Charles H Krebs (Address) 1520 N Wolfe St

15 Filed MAY 17 1921, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1921

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1921, to May 16, 1921, that I last saw him alive on May 16, 1921, and that death occurred, on the date stated above, at 11 50 P.M.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William Frazier M. D.

May 16/21 (Address) 1497 N Bay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem't	May 19 1921

20 UNDERTAKER ADDRESS

Wm Cahoon 2026 E Baltimore Ave

MAY 17 1921

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Broncho pneumonia

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53813

CERTIFICATE OF DEATH.

D 53813

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 61-4th Ave. - Wagners Pt. City St.: 25th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelaide Sipes

(a) RESIDENCE. NO. 61-4th Ave. Wagners Pt. City ST., 25th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Elongia Sipes

6 DATE OF BIRTH (month, day, and year) May 10 - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55.		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Henry Buech

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adelaide Buech

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Katie Maude Pollard (Address) 61 4th Ave. E. Brooklyn

15 Filed ....., 19 Robert P. Harrison, Registrar

MAY 17 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16th 1921.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5 1920, to May 16th 1921, that I last saw her alive on May 14th 1921, and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchio Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan. 8-1920

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William A Smith, M. D.

, 19 (Address) 816 - Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	5/18/21 19
20 UNDERTAKER Wm. Cook	ADDRESS 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53814

CERTIFICATE OF DEATH.

19 D 53814

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 689 W Mulberry St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Curtis

(a) RESIDENCE. No. 689 W. Mulberry St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Curtis

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacco

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bessie Satchell

(Address) 624 N Broadway

15 F[illegible] [illegible] TAUTE

MAY 18 1921 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1921, to May 16, 1921, that I last saw h[illegible] alive on May 16, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart
(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pul Hemorrhage Edema
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) F Woodward, M. D.

May 17, 1921 (Address) 909 N Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn A	May 18 19
20 UNDERTAKER	ADDRESS
A L Brown and Son	108 N. Monty

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53815

CERTIFICATE OF DEATH.

78 / D 53815

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1352 Carroll ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Louisa Clark

(a) RESIDENCE. No. 1352 Carroll ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Assistant at 1352 Carroll St

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Louisa Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles A. Clark
(Address) 1352 Carroll St

15 Filed MAY 18 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1921, to May 14, 1921, that I last saw h.e alive on May 13, 1921, and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) None.

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Baltimore.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. H. Wright, M. D.

(Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 18 1921
20 UNDERTAKER	ADDRESS
Samuel Hemsley	518 N. Gilmor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53816 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53816

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3142 Foster ave ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Stern

(a) RESIDENCE. NO. 3142 Foster ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Stern

6 DATE OF BIRTH (month, day, and year) May 27-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 45

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Moses Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rachael Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Jack Lewis

(Address) 1411 E Balto St

15 MAY 18 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1921

17

I HEREBY CERTIFY, That I attended deceased from March 30 1921, to May 17 1921, that I last saw h[illegible] alive on " 17 1921, and that death occurred, on the date stated above, at 4 am. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X Ray & Physical Sign

(Signed) C. S. Neer, M. D.

5/17/21 (Address) 1408 Eutaw Pk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sinai Memorial Park	May 18 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53817

CERTIFICATE OF DEATH.

18 V D 53817

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1605 Pennsylvania Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Dean

(Residence in Baltimore: No. 1605 Pennsylvania Ave. St.: yrs. 23 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH, ... November (Month), 5 (Day), 1898 (Year)

7-AGE, 23 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Dom

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Grey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sadie Mack

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Mack

(Address) 738 Hanford Ave

15- ROBERT F KRAUTER

Filed MAY 18 1921 191..... Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 15 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Incised wound of neck
1 hour
Incised wound of head
Instantaneous death (Homicide)
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. T. Hennessy M. D.
(Coroner.)

May 17 1921 (Address) 2802 Edgemere Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery — DATE OF BURIAL, May 15 1921

20-UNDERTAKER R E Gross — ADDRESS 1405 McElderry St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53818 HEALTH DEPARTMENT—CITY OF BALTIMORE 91 ✓

CERTIFICATE OF DEATH. 6-91 D 53818

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3828 Barrington Road ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adele N. Bloom,

(a) RESIDENCE. No. 3828 Barringotn Rd. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. time mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23rd. 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER W. Irving Bloom,

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York,

12 MAIDEN NAME OF MOTHER Adele Neuhan,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant W. I. Bloom,
(Address) 3828 Barrington Rd.,

15 MAY 18 1921 ROBERT J. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16th. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1921, to May 16, 1921, that I last saw h.. alive on May 16, 1921, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Measles 14 Days

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchs Pneumon

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Emma F. Krager, M. D.

5/16 1921 (Address) 1438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	May 18th 1921

20 UNDERTAKER David Goudelsin ADDRESS 118 W. Mt. Royal Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53819

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53819

CERTIFICATE OF DEATH.

43

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 N Eden ST.: 9 WARD)

2-FULL NAME Mary K Reid

(a) RESIDENCE. NO. 1408 N. Eden ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. [illegible] mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of William Reid

6 DATE OF BIRTH (month, day, and year) February 14th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Francis Locke

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Stout

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant William Reid
(Address) 1408 N Eden St

15 [illegible] MAY 18 1921 ROBERT P. LATTE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 6th, 1917, to May 17th, 1921, that I last saw h[illegible] alive on May 17th, 1921, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1920

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) L. M. C. Barber, M. D.

May 17th 1921 (Address) 1114 Harlem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 19th 1921
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 Ellamont

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53820

CERTIFICATE OF DEATH.

6-091 ✓

D 53820

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Patapsco St.. ~~West~~ East WARD)

2-FULL NAME Ruth J. Hughes.

(a) RESIDENCE. NO. 219 Patapsco St ~~West~~ East WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work C 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick J. Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mchenet Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Frederick J. Hughes

(Address) 219 Patapsco St

15 Filed ..... 19 ..... ROBERT P. CHAUTH Registrar

MAY 18 1921

Burial Permit Oleft

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1921

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1921, to May 17th, 1921, that I last saw h.. alive on May 17, 1921, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows: OVER

Bronchial Pneumonia

(duration) yrs. mon. 10 da.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Delcrett, M. D.

May 7, 1921 (Address) 621 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delta Pa	May 18 1921

20 UNDERTAKER Jos Joerdens Son

ADDRESS 217 E Pr.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

History of child having had measles before I Dr. Delevett attended

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53321

CERTIFICATE OF DEATH.

110 D 53321

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital St.: 45 Ward)

2-FULL NAME Mr. Sigmond Kahn

(a) RESIDENCE. No. 656 Pitcher St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Sigmond Kahn

6 DATE OF BIRTH (month, day, and year) July — 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster 045

(b) General nature of industry, business, or establishment in which employed (or employer) Vegetables

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wolf Kahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lindheim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Augusta Kahn (Address) 656 Pitcher St

15 Filed MAY 18 1921, 19.....

ROBERT P. BRUTE

Registrar

Burial is at Cl Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1921, to May 17, 1921, that I last saw him alive on May 17, 1921, and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Operation for Intestinal Adhesions

(duration) yrs. 96 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 17-21

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) I. H. Tannenbaum, M. D.

5/17, 19 21 (Address) U. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chevra Shalom Cem	5/19 1921
20 UNDERTAKER	ADDRESS
J. Ahrens Co.	1611 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 53822

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53822

CERTIFICATE OF DEATH.

X 92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Rebecca Waters

(a) RESIDENCE NO. Princess Anne, Maryland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. 8 ds. How long in U. S., If of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 8th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nun

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Princess Anne, Maryland

PARENTS

10 NAME OF FATHER Levin L. Waters

11 BIRTHPLACE OF FATHER (city or town) Princess Anne (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucretia Jones

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co (State or country) Maryland

14 Informant Arnold Elzey Waters
(Address) St. Paul St. & Mt. Royal-Ave.

15 Filed MAY 18 1921 ROBERT J. PAUL Registrar

Via Penn Railroad, Escort, Arnold E. Waters

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 14th, 1921, to May 17th, 1921,

that I last saw h[illegible] alive on May 17th, 1921,

and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? St Paul apartments, Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Wm H. Tabney M. D.

May 17, 1921 (Address) Easton, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Princess Anne, Md.	5/18, 1921.
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53823

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Rear of 601 Pratt St. St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Evans

(Residence in Baltimore: No. West Run A. A. Co. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Sgle

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, about 45 yrs. ....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labourer
(b) General nature of industry, business, or establishment in which employed (or employer)..... P.C.

9-BIRTHPLACE, (State or Country), U. S.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Evans

(Address) 1 Glenlouis Md.

15- Filed MAY 18 1921, 191.... ROBERT P. LAJTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Duration

(Duration) .....yrs.....mos.....ds.

(Signed) .....M. D. (Coroner.)

May 19, 1921 (Address) 1617 Bel Air

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	May 18, 1921
20-UNDERTAKER	ADDRESS
John E. Henderson	1602 E Monument

I. C. — Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

148068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53824

X 39

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Upton

(a) RESIDENCE. No. Perla and Ellicott City ST.

WARD. Ellicott City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura V. wife Same address

6 DATE OF BIRTH (month, day, and year) May 17-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Packer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joshua M Upton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Julia Buske

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Johns Hopkins Hospital Records.

15 Filed MAY 18 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 18, 1921, that I last saw him alive on May 18, 1921, and that death occurred, on the date stated above, at 4.51 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of jaw

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5/14/21

Was there an autopsy? No

What test confirmed diagnosis? Physical findings.

(Signed) J. B Kneale M. D.

5/18, 1921 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Ellicott City	5/21/21
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

information should be carefully supplied. AGE

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53825

43 D 53825

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Harris

(a) RESIDENCE. No. 2005 Robb St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Companion

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Ohio

PARENTS

10 NAME OF FATHER Benjamin Bowmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Urylery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Hospital Records, (Address) New City Hospitals.

15 MAY 18 1921

[illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1921 to May 16, 1921.

that I last saw her alive on May 16, 1921.

and that death occurred, on the date stated above, at 1:00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Left Breast

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Secondary anemia and Cachexia (duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1916

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Claud C Burton, M. D.

5-17-21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cem	May 19 1921
20 UNDERTAKER E A Windfield	ADDRESS 501 E 22

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state plainly anything supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53826

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 53826

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 6 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Pfeffer

(a) RESIDENCE. No. 204 N. Wolfe st. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Pfeffer

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pickle maker

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown 086

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry Pfeffer

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie Wilgarden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant: Hospital Records (Address) W.T.W.

15 Filed MAY 18 1921 ROBERT I. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1921, to May 17, 1921, that I last saw him alive on May 16, 1921, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, x-ray

(Signed) Wm. H. Fahrenbach, M.D.

5-17-21, 19 (Address) Municipal Tuberculosis Hos

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	May 19 1921
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2046 Eastern Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53827

CERTIFICATE OF DEATH.

6-091

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 431- W- 23 ST. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angelina Lehrato

(Residence in Baltimore: No. 431- W- 23 St.; 4 yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH. Mar 18, 1917 (Month) (Day) (Year)

7-AGE. 4 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Nicholas Lehrato.

11-BIRTHPLACE OF FATHER (State or Country). Italy.

12-MAIDEN NAME OF MOTHER. Katherine Metrangelo

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nick Lehrato

(Address) 431-W-23 St.

15- MAY 18 1921 Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 17, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16 1921, to May 18 1921, that I saw her alive on May 17 1921, and that death occurred, on the date stated above, at 11.30 P m. The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia following measles

(Duration) 0 yrs. mos. 7 ds.

(Signed) Roscoe Gibson M. D.

May 18, 1921. (Address) 1438 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Vincents Cemty

DATE OF BURIAL. May 20, 1921

20-UNDERTAKER McInnis Cook

ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIAN should state

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53828

CERTIFICATE OF DEATH.

115 D 53828

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3523 Barclay St. St.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Lenard

(a) RESIDENCE No. 3523 Barclay St. St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Lenard

6 DATE OF BIRTH (month, day, and year) Dec 15 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Geo E Lenard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng.

12 MAIDEN NAME OF MOTHER Emma Collen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eng.

14 Informant Jaime W Serpas (Address) 1734 Braddish Ave.

15 Filed MAY 18 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1921

17 I HEREBY CERTIFY, That I attended deceased from March 24 1921, to May 17 1921, that I last saw h[illegible] alive on May 17 1921, and that death occurred, on the date stated above, at 8.10 p m.

The CAUSE OF DEATH* was as follows:-

Cholecystitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Wm Stumph M.D., M. D.

5/17/1921 (Address) 40 E Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May. 20 1921
20 UNDERTAKER	ADDRESS
H. M. Cook	532 E. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Edward N. Delamore (See letter of Coroner & Commissioner of Police)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53829 — 79 — D 53829

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 410 W Mulberry ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas E. Delamore

(Residence in Baltimore: No. 410 W Mulberry St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Don't Know

6-DATE OF BIRTH, ... Don't Know, 1 .....
(Month) (Day) (Year)

7-AGE, about 45 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Don't Know
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Don't Know

PARENTS.

10-NAME OF FATHER, " "

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Sontheimer Thos. Sontheimer Inc.

(Address) New Orleans La.

15- Robert F. Harrison,

Filed ....., 191.....

MAY 1 1921 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May ..... 16..., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

..... (Duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know Grey

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Grossnickle M. D.
(Coroner.)

5-18-, 1921 (Address) 417 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence. New Orleans La.

19-PLACE OF BURIAL OR REMOVAL, New Orleans La. DATE OF BURIAL, May 19th, 1921

20-UNDERTAKER William Cook ADDRESS 502 E North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state very important. See instructions on back of certificate.

D53829

STATE OF LOUISIANA

PARISH OF ORLEANS

BEFORE ME, the undersigned authority, personally came and appeared:

MILTON W BOYLAN, who being duly sworn, deposes and says:

That he is and has been intimately acquainted with Edward N Delamore, son of the late George Delamore and Louisa Boylan; that the said Edward N Delamore is the same identical person who died at Baltimore, Maryland, on Monday May 16th 1921 and who was buried at New Orleans, Louisiana on May 21st 1921, from the parlors of Tharp Sontheimer & Tharp Inc; and that the said Edward N Delamore is the same identical person whose death certificate from Baltimore, read James E Delamore; that affiant saw the remains of said Edward N Delamore and positively swears as to the perfect identity between the said James E Delamore as stated in said certificate of death from Baltimore, and Edward N Delamore, which was his correct name.

SWORN TO AND SUBSCRIBED BEFORE ME
NOTARY THIS 23rd day of MAY A D
1921.

Milton W Boylan

Notary Public

DR. H. K. GORDUGH,
117 SARATOGA ST. WEST.
BALTIMORE, MD.

MAY 31 1921

5: 28121

D 53829

D. C. H Jonns
omnus Hosll
Balto Cty-

My Dear Doctor Your letter of may 27- inquiring as
the correct name of a man. named by me as
ms E. Delamore who died suddenly at 410 N Milly st
may 16th 1921. This was his name so far as my
formation was. This was obtained though the police
ept. If you have any good reason to think this
s not his correct name you have my consent
make the change on your records at the Health Dept
Yours truly
H K Gorsuch

D53829

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

EXECUTIVE OFFICE

HEALTH DEPARTMENT

C. HAMPSON JONES, M. D.
COMMISSIONER AND REGISTRAR, V S.

J. FREDERICK HEMPEL, M. D.
ASSISTANT COMMISSIONER

REED GAITHER,
SECRETARY

May 27, 1921.

Dr. H.K.Gorsuch,
117 W.Saratoga st.,
City.

Dear Dr. Gorsuch:-

If it will be convenient I should be pleased to have you call at this office this afternoon between three and five P.M. or tomorrow, Saturday between ten o'clock and twelve M. I desire to see you concerning a death certificate given by you of a man by the name of James E.Delamore, who died at 410 W.Mulberry street on May 16th. I have a sworn statement from New Orleans concerning this man's name, which says that instead of it being James E. Delamore that it is Edward N.Delamore. We have no right to make the change in this certificate without you are perfectly satisfied concerning it.

Yours respectfully,

C. Hampson Jones

Commissioner of Health.

CHJ/M

MAY 31 1921

D53829

June 1, 1921.

General Charles D. Gaither,
Commissioner of Police,
Court House, City.

Dear Sir:-

On May 25th I received a letter from Milton W. Boylan, Principal, Boylan's Detective Agency and Protection Police, New Orleans, asking us to change if it be permissible the name given in the death certificate by Coroner Gorsuch of James E. Delamore, who died in Baltimore City but formerly lived in New Orleans, to Edward N. Delamore, which is said to be the correct name. On the receipt of this letter I wrote to Dr. Gorsuch, coroner, who said that he had no objection whatever to the change in the name, if there is reason to believe that the name given by him is wrong, because he depended entirely upon the report of the Police Department as far as the name of the deceased was concerned. I, therefore, am writing to you to ask if there is any reason in the police records for believing that the correct name of the disease is James E.Delamore. If there is now proof in the hands of the police that the correct name is James E.Delamore, I suppose that it will be proper for us to make the change to Edward N.Delamore.

The face of the certificate given by Dr. Gorsuch shows the following: James E.Delamore died at 410 W.Mulberry street on May 16th, 1921. The deceased evidently was found dead or was known to have died suddenly because it was a coroner's case and referred to Dr. Harry K.Gorsuch, 117 W.Saratoga st.

Yours respectfully,

Commissioner of Health.

CEJ/M

POLICE DEPARTMENT
BALTIMORE, MARYLAND
OFFICE OF THE COMMISSIONER

CHARLES D. GAITHER
COMMISSIONER
JOSIAH A. KINSEY
SECRETARY

D 53829

June 3rd, 1921.

Dr. C.Hampson Jones,
Commissioner of Health,
Baltimore, Md.

Dear Dr. Jones:

In reply to your letter of June 1st, in reference to death certificate made out as of James E. Delamore, be changed to Edward N. Delamore,- I have had this matter investigated and find that this man's proper name should have been Edward N. Delamore,- that under the name of Edward N. Delamore he rented and occupied room at #410 W. Mulberry Street prior to his death. The error was caused by the finding of some communications in his pockets addressed to James E. Delamore.

I have directed that the records of this Department be changed as above.

Yours very truly,

Chas. D. Gaither

Charles D. Gaither,
POLICE COMMISSIONER.

C

JUN 4 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53830 ✓ D 53830

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4502 Loretta ave. St. Lauraville Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Walch

(a) RESIDENCE. No. 4502 Loretta ave. St., Lauraville Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Walch

6 DATE OF BIRTH (month, day, and year) April 27th 1842

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	79	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Deer

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Imbock

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant William Walch (Address) 4502 Loretta Ave. Lauraville

15 Filed Robert P. Harrison, Registrar

MAY 18 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to May 16, 1921, that I last saw her alive on May 15 1921, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sarcoma of Stomach (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Post mortem

(Signed) [illegible], M. D.

May 17 1921 (Address) 4700 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 19 21
20 UNDERTAKER	ADDRESS
Fred'k Lassahn & Sons	Fullerton Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 53831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53831

CERTIFICATE OF DEATH.

+74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Shores

(a) RESIDENCE. No 942 N 7th St Chester. Penn WARD. Chester Pa.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28-1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Jacob Shore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Marines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Johns Hopkins Hospital Robert P Harrison, Guard

15 Filed ....., 19 ..... Registrar

Y 18 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18—1921

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to May 18, 1921, that I last saw him alive on May 18, 1921, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor
Cerebellar.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. E. Dandy, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chester Pa	May 18 1921
20 UNDERTAKER	ADDRESS
H E Hughes	Hartsville Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement should state TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53832

CERTIFICATE OF DEATH.

REGISTERED No. C 66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 W. Lanvale St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Archibald M. Dobbin

(Residence in Baltimore: No. 1713 W. Lanvale St. St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, May 30, 1831 (Month) (Day) (Year)

7-AGE, 89 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer): City Official of Knoxville Tenn.

9-BIRTHPLACE, (State or Country), Knoxville Tenn.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nena Gardner (daughter)

(Address) 1713 W. Lanvale St.

15-

Filed ....., 191.....

Robert P. Harrison,

8 1921 Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1921, to May 18 1921, that I saw h alive on May 17 1921, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) yrs. 2 mos. 11 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. E. Young M. D.

May 18, 1921. (Address) 1601 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery

DATE OF BURIAL, May 20, 1921

20-UNDERTAKER A. E. Hughes.

ADDRESS 1217 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53833

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53833

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD) 34

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warner Mathews

(a) RESIDENCE. No. Clarksville Md ST., WARD. Clarksville Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. 15 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Matthews

6 DATE OF BIRTH (month, day, and year) Aug 10 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer Co. Commrs of Balto Co.

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) ✓

12 MAIDEN NAME OF MOTHER Louise Pratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records (Address)

15 Filed MAY 18 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 18 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-2-21, 19—, to 5-18-, 19 21, that I last saw h[illegible] alive on 5-18, 19 21, and that death occurred, on the date stated above, at 2:10 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Both kidneys, peritoneum & [illegible].

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lab. clo

(Signed) Zeke Hooper, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hopkins Chapel Howard Co	May 21, 1921
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

GE should be stated EXACTLY. PHYSICIAN should state
hat it may be properly classified. Exact statement of OCCUPA-
ns on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53834

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53834

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 S. Smallwood St. St.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie M. Bauer

(a) RESIDENCE. No. 214 S. Smallwood St. St., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Bauer

6 DATE OF BIRTH (month, day, and year) Dec. 23rd 1921

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Rupp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Yost

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Bauer (Address) 214 S. Smallwood St.

Filed MAY 18 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1920, to May 16, 1921, that I last saw her alive on May 16, 1921, and that death occurred, on the date stated above, at 5.45 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Chas H. Bulwinkle, M. D.

May 17, 1921 (Address) 1100 6 Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	May 19 1921

20 UNDERTAKER Jos. B. Cook ADDRESS 1003 N. Balto

CAUSE should be stated EXACTLY. PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53835 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 53835

CERTIFICATE OF DEATH. REGISTERED No. C

1-PLACE OF DEATH 4920 Park Heights Ave

CITY OF BALTIMORE (N. Woodmere ST.: 27 WARD)

2-FULL NAME Daniel H. Fredrick

(Residence in Baltimore: No. 4920 Park Heights Ave St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Date)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widower

6-DATE OF BIRTH May 6, 1847
(Month) (Day) (Year)

7-AGE, 74 yrs. 2 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Little

(Address) 2700 Edmondson Av

15-

MAY 18 1921 Robert P. Harrison,
(Month) (Day) (Year)
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Morrison M. D.
(Coroner)
May 20, 1921 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	May 20 1921
20-UNDERTAKER	ADDRESS
Geo W Little	2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53836

1 PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital St.; WARD)
REGISTERED No. C 175

2-FULL NAME. Charlie Beard.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1 Lee. St.; yrs., mos. ds.)
Cockeysville Md (1 hour)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Apr. (Month) ..... (Day), 1912 (Year)

7-AGE, 9 yrs. 1 mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Cockeysville Md

PARENTS.
10-NAME OF FATHER, Edward Beard
11-BIRTHPLACE OF FATHER (State or Country), Md
12-MAIDEN NAME OF MOTHER, Mary Bishop
13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. F. Chatsman Undertaker
(Address) Phone 193 Md

15- Robert P. Harrison,
Filed ....., 191.....
MAY 18 1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Auto Accident
Fracture of Skull.
(Duration) ..... yrs. ..... mos. 1/2 ds.
CONTRIBUTORY (Secondary) Shock.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Edwin Bibby M. D.
(Coroner)
May 18 1921 (Address) 1432 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence. Cockeysville Md.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cockeysville Md	May 19, 1921
20-UNDERTAKER	ADDRESS
Samuel L Hensley	5 E Biddle St

18.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53837

CERTIFICATE OF DEATH

64

1-PLACE OF DEATH Ellamont st. near Frederick Road

CITY OF BALTIMORE: (No. Carroll Station ST.: Balto 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Frizzell

(a) RESIDENCE. No. Ellamont st near Frederick Road Carroll Sta Balto Md, WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret A. Frizzell.

6 DATE OF BIRTH (month, day, and year) Aug 30, 1846

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Art Dealer 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md.

PARENTS

10 NAME OF FATHER Miman Frizzell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md.

12 MAIDEN NAME OF MOTHER Lily A. Hilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md.

14 Informant Mrs. Herbert Frizzell (Address) Carroll Sta. Balto Md

15 Filed MAY 18 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1921, to May 17, 1921, that I last saw h.. alive on May 15, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Henry J. Kahn, M. D.

5/18, 1921 (Address) 2317 Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 20 1921

20 UNDERTAKER George R. Smith ADDRESS 1000 Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53833

CERTIFICATE OF DEATH.

28 D 53833

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1030 Eutaw St St.: 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Carter

(Residence in Baltimore: No. 1030 Eutaw St

23 St.; yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH, June (Month), 6 (Day), 86 (Year)

7-AGE, 34 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): in family

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Green

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Frances Ricby

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Green

(Address) 1030 Eutaw St

15- CORONER'S CERTIFICATE

Filed MAY 18 1921 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Pearson M. D. (Coroner.)

May 18, 1921 (Address) 700 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	May 19, 1921
20-UNDERTAKER	ADDRESS
Joseph A Farrell	2319 Division St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53339

CERTIFICATE OF DEATH.

151 D 53339

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 N. Stricker ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sherman A Borley

(a) RESIDENCE. NO. 937 N. Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 18 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Sherman Borley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Blanche Townsend

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City Md.

14 Informant Sherman Borley
(Address) 937 N. Stricker St.

15 Filed MAY 19 1921, 19... ROBERT J. KRAUTER Registrar
Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1921, to May 18, 1921, that I last saw him alive on May 18, 1921, and that death occurred, on the date stated above, at 1-15 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth. (6 months.) (Pregnancy)

One of twins.

... (duration) — yrs. — mos. — ds. one hour

CONTRIBUTORY (Secondary) ...

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. L. McCarthy, M. D.

, 19 (Address) 406 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	May 19 1921
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53840

CERTIFICATE OF DEATH.

151

D 53840

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9372 S. Hanover ST.: 16 WARD)

2-FULL NAME Adhesion Burley

(a) RESIDENCE. No. 9372 S. Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md.

PARENTS

10 NAME OF FATHER Sherman Burley

11 BIRTHPLACE OF FATHER (city or town) Carroll Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Blondel Townsend

13 BIRTHPLACE OF MOTHER (city or town) Balto. City
(State or country) Md.

14 Informant Sherman Burley
(Address) 9372 S. Hanover St.

15 MAY 19 1921 [illegible] Registrar
[illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 - 1921

17 I HEREBY CERTIFY, That I attended deceased from May 18 - 1921, to May 18, 1921, that I last saw him alive on May 18, 1921, and that death occurred, on the date stated above, at 12-45 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth, one of twins, 6 months pregnancy. 30 minutes

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thos. C. McCarthy, M. D.

, 19 (Address) 906 S. Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	May 19" 21 19
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W. Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 D 53841

1-PLACE OF DEATH Md General Hospital 70

REGISTERED NO.....

CITY OF BALTIMORE (No 2021 W Lexington ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C. Alexander Henderson

(a) RESIDENCE. NO. 2021 W. Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or, WIFE of) Jennie L Henderson

6 DATE OF BIRTH (month, day, and year) Dec. 5/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Cornelia L. Buck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs Florence Combs
(Address) 2021 W Lexington St

15 Filed MAY 19 1921 19 ... Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 26 1921, to May 18 1921.

that I last saw him alive on May 18 1921.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows: over

Cerebral Hemorrhage Obstruction

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aneurysm Ascending Aorta

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 4/27/21

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Fred B. Smith, M. D.

19 (Address) Md. Med. Chirp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	May 21 1921
20 UNDERTAKER	ADDRESS
Henry H Jenkins & Son	Orchard & Mc Elliot St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Obstruction due to aneurysm
which was not treated
Operation for aneurysm

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 53842

CERTIFICATE OF DEATH

79

D. 53842

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 912 N Carrollton av ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sarah Ellen Wirt

(Residence in Baltimore: No. 912 N Carrollton av St.; 73 yrs. 11 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: June (Month) 14 (Day), 1847 (Year)

7-AGE: 73 yrs. 11 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: William Buehler

11-BIRTHPLACE OF FATHER (State or country): Hanover Pa.

12-MAIDEN NAME OF MOTHER: Elizabeth Davis

13-BIRTHPLACE OF MOTHER (State or country): Hanover Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Records Family Bible (No Surviving relatives)

(Address) 912 N Carrollton Ave

15-MAY 19 1921 Filed ....., 191.... ROBERT J. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 17th (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5th, 1921, to May 17th 1921, that I saw her alive on May 16th, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

..... (Duration) many yrs. ..... mos. ..... ds

Contributory (SECONDARY) Chronic Nephritis

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) John S Cunningham M. D.

May 17th, 1921. (Address) 1826 Bolton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: May 19, 1921.

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53843

HEALTH DEPARTMENT—CITY OF BALTIMORE

120

D 53843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1634 McElderry ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Grobs

(a) RESIDENCE. No. 1634 McElderry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in whieh employed (or employer) Cook

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) born in Baltimore

PARENTS

10 NAME OF FATHER Sam Goss

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Elliott
(Address) Undertaker

15 Filed ....., 19 .....
MAY 19 1921
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1921, to May 18, 1921
that I last saw h[illegible] alive on May 18, 1921
and that death occurred, on the date stated above, at 12 a. m.
The CAUSE OF DEATH* was as follows:

Brights Disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Grippe in Jan 1921

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation preeede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No

(Signed) D C Burns, M. D.

May 19 1921 (Address) 1218 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem Cemetery	May 23 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1726 Ashland Ave

mation should be carefully supplied. All items should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 53844

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie White

(a) RESIDENCE. No. 2808 Evergreen Terrace ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Henry Chappell

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Jane Cullis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Hospital Records, (Address) New City Hospital.

15 [illegible] Registrar

MAY 1 1921

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1921 to May 17, 1921.

that I last saw her alive on May 17, 1921.

and that death occurred, on the date stated above, at 10:30 Pm.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No especial test.

(Signed) B. Herman, M. D.

5/18/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	May 20 1921
20 UNDERTAKER William Cook	ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53845

CERTIFICATE OF DEATH.

41 D 53845

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Maryland Ave, Westport 25 WARD)

2-FULL NAME Elizabeth Salt Turner

(a) RESIDENCE. No. 307 Maryland Ave, Westport ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 31 yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
(or) WIFE of Thomas William TURNER

6 DATE OF BIRTH (month, day, and year) 15th April 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	Fifty nine 59	one 1	three 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Broadpresure, Cheshire - England

PARENTS

10 NAME OF FATHER John Astbury SALT

11 BIRTHPLACE OF FATHER (city or town) Prestonbrook (State or country) England

12 MAIDEN NAME OF MOTHER HELEN Woodward

13 BIRTHPLACE OF MOTHER (city or town) Prestonbrook (State or country) England

14 Informant Thos. Wm Turner
(Address) 307 Md Ave - Westport

15 Filed MAY 18 1921 ROBERT I KRAUTH Registrar

Burial Permit 61008

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 18 May 1921

17 I HEREBY CERTIFY, That I attended deceased from 10th Dec. 1920. to 18 May 1921.
that I last saw her alive on 17 May 1921.
and that death occurred, on the date stated above, at 4 9. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid Intestine and pelvis

(duration) 8 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) General metastases

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of 29 Dec. 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Caldwell Warfield, M. D.
18 May '21 (Address) 234 Md Ave, Westport

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	May 20 1921
20 UNDERTAKER	ADDRESS
McClain Cook	502 E Nall

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53846 D 53846

CERTIFICATE OF DEATH.

136

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1554 Clifton ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Violet Emma Shipley

(a) RESIDENCE. No. 1554 Clifton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. — mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leslie R Shipley

6 DATE OF BIRTH (month, day, and year) Jany 9-1885

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	36	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife - 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) London England.

PARENTS

10 NAME OF FATHER Gilbert Rowland.

11 BIRTHPLACE OF FATHER (city or town) (State or country) London England

12 MAIDEN NAME OF MOTHER Mrs Emma E.A. Hardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London England

14 Informant Leslie R Shipley (Address) 1554 Clifton Ave

15 Filed . 19 ROBERT J. BAUER Registrar

MAY 19 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1921, to May 18, 1921, that I last saw her alive on May 18, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: Due

Placenta Previa Dilatation

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Childbirth — —

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) George C. Shannon, M. D.

, 19 (Address) 700 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 21 1921

20 UNDERTAKER J. H. Cook ADDRESS 562 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Normal birth & about four hours after dilatation of heart & death occurred. No hemorrhage no kidney condition, no accident of pregnancy other than dilated heart.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D 53847

1-PLACE OF DEATH Md. Gen'l. Hosp.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 11 WARD)

2-FULL NAME Howard Arthur Englar

(a) RESIDENCE. No. 622 Edgewood Ave ST., 16 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8/21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Howard S. Englar

11 BIRTHPLACE OF FATHER (city or town) Carroll Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Dahlin

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Howard S. Englar
(Address) 622 Edgewood Ave

15 Filed MAY 19 1921 ROBERT I. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 8 1921, to May 18 1921, that I last saw him alive on May 18 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Extra-Cranial Tumor of Face

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Fractured Skull

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? N.G.H.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Fred B. Smith M. D.

(1921 Address) Md. Gen'l. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL May 19 1921.

20 UNDERTAKER William Cook

ADDRESS 502 E Nath

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Instrumental delivery

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53848

CERTIFICATE OF DEATH.

28 D 53848

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 Friendship ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shanna Plummer

(a) RESIDENCE. NO. 709 Friendship ST., WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Jan. 2nd 1885.

7 AGE: Years 36 Months 4 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: 2

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George Plummer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Earl Morton
(Address): 736 E. Madison

15 Filed MAY 19 1921 ROBERT I. KRAMER Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 6th, 19 21, to May 16th, 19 21, that I last saw h[illegible] alive on May 16th, 19 21, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What [illegible] confirmed diagnosis? Clinical

(Signed) Hulet B. A. Meyer, M. D.

(Address) 1031 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: May 19th 1921

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53849

D 53849

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 Dover St.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Burke

(a) RESIDENCE. No. 730 Dover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Single Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Enterprise Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Daniel Easton
(Address) 916 Pa ave

15 Filed MAY 19 1921 ROBT. J. BRESNAHAN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1921, to May 18, 1921, that I last saw h[illegible]live on May 16, 1921, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Boyd, M. D.
18-5, 19 21 (Address) 602 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 23 1921
20 UNDERTAKER	ADDRESS 916 Pa ave
Daniel Easton	

N. B.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK

Joseph Handler or Handler

D 53850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 D 53850

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital, St.: 3 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

2-FULL NAME Joseph Handler or Joseph Handler

(Residence in Baltimore: No. 1515 Eastern ave' St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Don't Know, 1 (Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophia Handler

(Address) 1515 Eastern

15- FILED MAY 19 1924 ROBERT J. TRAVIS Registrar

Burial Permit 07817

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy ~~or inquiry.~~) thereon and from the evidence obtained by said (Inquest, autopsy ~~or inquiry.~~) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

From a Bullet wounding the Abdomen Liver From a pistol in the hands of Some unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D. (Coroner.)

5-17-, 1924 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, May 17 1924

20-UNDERTAKER Jacot Lewis ADDRESS 1411 E. Lee

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

D 53851

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2819 Riggs Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Henry Frey

(a) RESIDENCE. No. 2819 Riggs Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Frey

6 DATE OF BIRTH (month, day, and year) Oct 5 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper 09

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Peter Frey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Bartels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Frey
(Address) 2819 Riggs Ave

15 MAY 19 1921 [illegible] FRANKEL
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan - 10, 1921, to May - 16 - 21 19, that I last saw h— alive on May - 16, 1921, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Prostatic - (Malignant -) Carcinoma

(duration) yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion - Visceral hemorrhage

(duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? City -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) M. D.

17/5/1921 (Address) 125 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	May 19 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Shipley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53852

8-091

D 53852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 359 Main at Mt Winans ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora A Shipley

(Residence in Baltimore: No. 359 Main at Mt Winans St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 26, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 11 mos. 8 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Peter Shipley

11-BIRTHPLACE OF FATHER (State or Country), West Virginia

12-MAIDEN NAME OF MOTHER Amanda Fields

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amanda Fields

(Address) Mt Winans

15- [illegible]

Filed MAY 19 1921 191.. Burial Permit Record

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1921, to May 18 1921, that I saw h[illegible] alive on May 18 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Whooping cough.

(Duration) 10 yrs. 12 mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho pneumia.

(Duration) 12 yrs. 10 mos. 2 ds.

(Signed) Raymond Glann M. D.

May 19, 1921 (Address) Oakland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death [illegible] yrs. ..... mos. ..... ds. In the State 1 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Residence

Former or usual residence Baltimore

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery — DATE OF BURIAL. May 22, 1921

20-UNDERTAKER John J Fields — ADDRESS 1200 W Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53853

CERTIFICATE OF DEATH.

D 53853

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Peraringer.

(a) RESIDENCE. NO. 3109 Elliott ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank H. Peraringer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Alice Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Frank H. Peraringer
(Address) 3109 Elliott St.

15 Filed MAY 19 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 18, 1921, that I last saw him alive on May 18, 1921, and that death occurred, on the date stated above, at 7:10 a.m.

The CAUSE OF DEATH* was as follows:

Scarlet fever.

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What was confirmed diagnosis? Pneumococcus culture from pus aspirated.

(Signed) B. MacLorann M. D.

May 8 1921 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	May 19 1921
20 UNDERTAKER Lilly and Zile	ADDRESS 403 S. Mt. Ave.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53854

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53854

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 Oak ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Hibler

(a) RESIDENCE. NO. 2109 Oak ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER George J. Hibler

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Lillian Rochester

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mr. George J. Hibler

(Address) 2109 Oak St

15 Filed MAY [redacted] 19 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1921, to May 18, 1921,

that I last saw him alive on May 17, 1921,

and that death occurred, on the date stated above, at 6:25 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

About 6 mo. 8 weeks.

(duration) no yrs. no mos. 10 ds.

CONTRIBUTORY (Secondary) Congenital Debility

(duration) no yrs. no mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Premature Birth

(Signed) Raymond Glenn M. D.

1921 (Address) Gaithersburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Joseph's Cemetery Baltimore Md	May 19 1921
20 UNDERTAKER	ADDRESS
Henry Storck Son	1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 43 D 53855

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Ensor St ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Lee Slade

(a) RESIDENCE. No. 1241 Waller St. S.E. Wash. D. C. ST.: WARD. Washington DC.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Slade

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Fred Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Blanche White

(Address) 2002 McCulloh St

15 Filed MAY 19 1921 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1921

17 I HEREBY CERTIFY, That I attended deceased from March 29 1921, to May 17 1921, that I last saw her alive on May 17 1921, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy + Blood Poison

I

Carcinoma of Breast

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast (duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Hugh Kennard M. D.

5-17 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 20 1921
20 UNDERTAKER John A. Frazier	ADDRESS 142 Mitchell

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53856

CERTIFICATE OF DEATH.

78

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1344 Stockton ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bias

(a) RESIDENCE. No. 1344 Stockton ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Nettie Bias

6 DATE OF BIRTH (month, day, and year) 1-12-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	5	5	

8 OCCUPATION OF DECEASED 074

(a) Trade, profession or particular kind of work Day Laborer, (Stevador)

(b) General nature of industry, business, or establishment in which employed (or employer) Loading Ships

(c) Name of employer Hodges & Co.

9 BIRTHPLACE (city or town) Ann Arundle Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Bias

11 BIRTHPLACE OF FATHER (city or town) Ann- (State or country) Arundle Co, Md.

12 MAIDEN NAME OF MOTHER Serina Hall

13 BIRTHPLACE OF MOTHER (city or town) Ann- (State or country) Arundle Co. Md.

14 Informant Nettie Bias
(Address) 1344 Stockton St.

15 Filed MAY 19 1921 [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17 - 1921

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1921, to May 17, 1921, that I last saw him alive on May 16, 1921, and that death occurred, on the date stated above, at 3.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None.

(Signed) George C. Page, M. D.

, 19 (Address) 1710 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn MAY 19 1921	19
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

PLACE OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53857 D 53857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 Etting ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Scott.

(a) RESIDENCE. No. 2310 Etting ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Scott.

6 DATE OF BIRTH (month, day, and year) Sept 2 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Guard

(c) Name of employer at Large Woodyard Co

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Scott.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nebraska

12 MAIDEN NAME OF MOTHER Fizzie Gibson

13 BIRTHPLACE OF MOTHER (city or town) Elwood (State or country) Ind

14 Informant Annie Scott (Address) 2310 Ettin

15 Filed MAY 19 1921 ROBERT F. KRAMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1921

17 I HEREBY CERTIFY, That I attended deceased from mar 30, 1921, to may 16, 1921, that I last saw h... alive on may 16, 1921, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of pleura

Peritonitis "General"

"intestinal perforation"

(duration) yrs. mos. 1 ds. 0

CONTRIBUTORY (Secondary) Syphilis 7 years

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Barnard T Gunst, M. D.

5/18, 1921 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Baltimore Co Md DATE OF BURIAL 19 MAY 1921

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53858

CERTIFICATE OF DEATH.

47 D 53858

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Harford ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Leo. Burlage

(a) RESIDENCE. NO. 1002 Harford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

No

6 DATE OF BIRTH (month, day, and year) Dec 10. 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles J Burlage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Susan Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Mary's Co Md

14 Informant Father
(Address) 1002 Harford Ave

15 Filed MAY 19 1921 [illegible] Registrar
Burial (or removal) Order

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar 29 1921 to May 18 1921 that I last saw her alive on May 17 1921 and that death occurred, on the date stated above, at 5-45 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis due to Inflamatory Rheumatism

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Loss Compensation & Related Cont (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Burlage M. D

(Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Holyoke Lawn Cemetery	May 21 1921

20 UNDERTAKER Elmer W Conklin ADDRESS 424 E Eager St

Spec.—6-9-19—H. P. Co.—2000 Blks.

D 53859

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 53859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 426 North Front St ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Ennalo

(a) RESIDENCE. No. 426 North Front St ST.: X WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Milburn Ennalo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge. Md.

12 MAIDEN NAME OF MOTHER Lydia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Father. Milburn Ennalo

(Address) 426 N Front St

15 Filed MAY 19 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/21 19

17 I HEREBY CERTIFY, That I attended deceased from 5/18/21, 19..., to 5/18/21, 19..., that I last saw h.r alive on 5/18/21, 19..., and that death occurred, on the date stated above, at 11,20 P m.

The CAUSE OF DEATH* was as follows:

Prematur. Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Israel Hardwood, M. D.

, 19 (Address) 426 North Front St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery.	May 19 1921
20 UNDERTAKER	ADDRESS
Milton Davis	413 N Eden St

PROPER CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53860

CERTIFICATE OF DEATH.

130

D 53860

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St.: 14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen F. Pratt

(a) RESIDENCE. No. 1934 Druid Hill Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Married

5a If married, widowed, or divorced
If ~~HUSBAND~~ of
(or) ~~WIFE~~ of Harry T. Pratt

6 DATE OF BIRTH (month, day, and year) Aug 15. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	9	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward Causey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Orbia Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry T. Pratt
(Address) 1934 Druid Hill ave

15 Filed MAY 19 1921 ~~REGISTRAR~~ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1921, to May 17, 1921, that I last saw h Ex alive on May 16, 1921, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Chronic Pelvic Inflammatory Disease
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes no Date of April 8/21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. McCard, M. D.
, 19 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cmty	May 20 21
20 UNDERTAKER George H. Holland	ADDRESS 1831 Druid Hill Ave

IMPORTANT: PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. F. Co.—1000 Bks.

(See affadavit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53861

64 D 53861

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 427 S. Pulaski St. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hanicofsky

(a) RESIDENCE. NO. 427 S. Pulaski St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48 56				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1411 E. Baltimore

15 MAY 19 1921 ROBERT J. KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1921

17

I HEREBY CERTIFY, That I attended deceased from May 14th, 1921, to May 19, 1921, that I last saw her alive on May 19, 1921, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Hemiplegia)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs, Myocarditis

Coma

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Joseph Eichner, M. D.

19 (Address) 1516 Madison Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Highview Washington Rd.	May 21 1921

20 UNDERTAKER Jack Lewis, ADDRESS 1411 E. Balto

TION is very important. See instructions on back of certificates.

it may be properly classified. Exact statement of OCCUPA-

PHYSICIANS should state

#D 53861

May 28, 1921

City of Baltimore) SS
State of Maryland)

I hereby take oath that the age of my deceased wife at the time of her death was forty eight (48) years.

Max Hankofsky

Personally appeared before me, Max Hankofsky, and known to me personnally that the above statement is correct to the best of his knowledge and belief.

Sworn before me on the 28th day of May, 1921

Maurice Lesnar
Notary Public

My commission expires May 3, 1922.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53862

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Public Health Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. ST.: 44 WARD)

REGISTERED No. 2437

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lewis

(a) RESIDENCE. No. US. Public Health Hosp. #56 Fort McHenry Baltimore Md. ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs C A Lewis

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73 yrs.	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar Breadrick Registrar
(Address) US. PHS Hosp. #56 Ft. McHenry

15 Filed MAY 19 1921 ROBERT J. BAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17

I HEREBY CERTIFY, That I attended deceased from May 5 1921 to May 18 1921

that I last saw him alive on May 18 1921

and that death occurred, on the date stated above, at 6'20 a.m.

The CAUSE OF DEATH* was as follows:

Syphilis general

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis chronic

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? Yes

What test confirmed diagnosis? Exam, Lab report

(Signed) Thomas R Paynes D.

, 19 (Address) Senior Surgeon (R) P.H.S.

US. PHS Hosp. #56 Ft McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Portsmouth Va	May 20 1921

20 UNDERTAKER ADDRESS

E J Bunting 1460 Battery ave

IT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 53863

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Katz

(Residence in Baltimore: No. 220 S. Caroline St.; abt 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1854 (Year)

7-AGE, 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Levy

(Address)..... 1411 E. Balto.

15- Filed MAY 19 1921, 191... ROBERT F. HAUTEL Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH May 18 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyanosis Heart Disease

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) H. Emil Grady M. D.
(Coroner.)

....., 191... (Address) 411 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Sinai DATE OF BURIAL, May 20 19 21

20-UNDERTAKER Jacob Lewis, ADDRESS 411 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53864

CERTIFICATE OF DEATH.

91-079

D 53864

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1237 William St. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Lambert

(Residence in Baltimore: No. 1237 William St St.; urban yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, April (Month) 13 (Day), 1857 (Year)

7-AGE,	If LESS than 1 day,
63 yrs. 1 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James T. Taylor

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annie Howard

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Lambert

(Address) 1237 William St.

15-Filed MAY 19 1921, 191.... Special Tax Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 17 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 12 1921, to May 17 1921, that I saw her alive on May 17 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Cardiac Insufficiency

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia Cardiac Insufficiency

(Duration) yrs. mos. 5 ds.

(Signed) Frances A Carpenter M. D.

May 18, 1921. (Address) 2101 Madison Ave Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pratt Cem

DATE OF BURIAL, 5/20, 1921

20-UNDERTAKER J. F. Taylor & Sons

ADDRESS 1318 E. Eager St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53865 D 53865

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 22 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Woelfer

(Residence in Baltimore: No. 607 Hanover St St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widower

6-DATE OF BIRTH, July 11, 1856 (Month) (Day) (Year)

7-AGE, 64 yrs. 10 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 017

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Andrew M. Woelfer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Amelia —

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Max Woelfer

(Address) 607 Hanover St.

15 MAY 19 1921 Filed....., 191... ROBERT J. BAUER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5-16 1921, to 5-18 1921, that I saw h[illegible] alive on 5-18 1921, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(Duration) yrs. mos. 4 ds.

(Signed) Edwin S. Levy M. D.

5-18-1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, May 20, 1921

20-UNDERTAKER F. A. Frame & Son ADDRESS 763 Hanover

GROSS OR PENCIL impair this, as it may be property examined. EACH statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53866

35

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 133 Maine Ave ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Meil

(a) RESIDENCE. NO. 133 Maine Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Meil

6 DATE OF BIRTH (month, day, and year): June 4-1879

7 AGE — Years: 41 — Months: 10 — Days: 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Roth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lena Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Henry Meil 133 Maine Ave

15 Filed 191921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from December, 1920, to May 17, 1921, that I last saw her alive on May 17 - 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

General Tuberculosis

Probably (duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Benj. D. Harden, M. D.

5/19, 1921. (Address) 216 N. Castle Line St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem — DATE OF BURIAL: May 21 1921

20 UNDERTAKER: J. Kerney & Co — ADDRESS: Lobs Glean

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53867

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry S. Franc

(a) RESIDENCE. No. 731 W. State ST., WARD. Trenton, N. J.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Harry S. Franc

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retail furniture business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Leopold Franc

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ida Heyn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address) Union Memorial Hospital

15 Filed MAY 19 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15th, 1921, to May 18th, 1921, that I last saw him alive on May 18th, 1921, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Aneurysm of Hepatic Artery

(duration) Symptoms 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Jaundice (6 weeks)
Rupture + haemorrhage (Terminal)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) [illegible], M. D.

May 18 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trenton N. J.	May 19 1921

20 UNDERTAKER Davidsonheim ADDRESS 1187 W. Pratt St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53868 HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 53868

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Joseph O'Brien

(a) RESIDENCE. NO. Preston Valley Ho. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred about 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Flaherty.

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael O'Brien.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Maloy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sister Florence. (Address) Preston Valley

15 Filed MAY 19 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from No Record, 19.., 19.., 19..,

that I last saw h[illegible] alive on May 15, 1921,

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute bronchial asthma

Autop

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

May 18, 1921 (Address) 1133 Valley m

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 21, 1921
20 UNDERTAKER	ADDRESS
Henry Hook Son	1301 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 19 1921

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53869

D 53869

CERTIFICATE OF DEATH.

REGISTERED NO. C 19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Anna Stickler (Stickler)

(Residence in Baltimore: No. 1634 Barnes St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) 13 (Day), 1887 (Year)

7-AGE, 33 yrs. 9 mos. 5 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Francis Jindra

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Sophia Havornek

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Henry L. E. Stickler

(Address) 1634 Barnes St

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

MAY 19 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 18 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4-26 1921, to 5-8 1921, that I saw h[illegible] alive on May 18 1921, and that death occurred, on the date stated above, at 2 P. M.,

The CAUSE OF DEATH* was as follows:

Subacute Endocarditis

(Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. J. Davidson M. D.

5-18, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State 33 yrs. 9 mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1634 Barnes St

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemy — DATE OF BURIAL, May 21, 1921

20-UNDERTAKER Henry Hoeck & Son — ADDRESS 1301 E Eager St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Benedikt)

D 53870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

D 53870

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 962 N. Chapel ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Benedikt

(a) RESIDENCE: NO. 962 N Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Benedikt

6 DATE OF BIRTH (month, day, and year): January 1850

7 AGE: Years 71; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Frantsek Benedikt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Josepha Holancova

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: John Benedikt. (Address): 948 N Chapel

15 Filed ..... 19.....

Robert P. Harrison Registrar

Burial Permit Clerk.

MAY 19 1921

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIAN should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1921, to May 17, 1921, that I last saw h alive on May 17, 1921, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Cardiac Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Brown, M. D.

5/17/21 (Address) 811 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: May 20 1921

20 UNDERTAKER: Frank Evans & Son

ADDRESS: 1916 Eastern Ave

D 53871

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53871

CERTIFICATE OF DEATH.

X 175001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Schmuck.

(Residence in Baltimore: No. 1 day Mercy Hospital St. yrs. mos. 1 ds.)

Morris Ave below Brooklyn P.O. Anne Arundel Co. Md

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 19th, 1868
(Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Bernard Freesmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Thelman

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos Schmuck

(Address) Annapolis Rd. Brooklyn

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk Registrar.

MAY 19 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident
Multiple Fractures
(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock.
(Duration) yrs. mos. 1 ds.

(Signed) Geo. Edwin Wade M. D.
(Coroner.)

May 19, 1921 (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Anne Arundel Co. Md.

19-PLACE OF BURIAL OR REMOVAL, Holy Cross 086

DATE OF BURIAL, 5-20, 1921

20-UNDERTAKER E & B Harle

ADDRESS 115 E Wash

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 53872 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 53872

151

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Cedar Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 7 mos twins of O.S. & R. Kepler

(Residence in Baltimore: No. 208 Cedar Ave St.; ..... yrs., ... mos. 19 hours ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, May 18, 1921
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 19 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Orlando S. Kepler

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia Pa.

12-MAIDEN NAME OF MOTHER Rose Cohn

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rose Kepler

(Address) 208 Cedar Ave

15- Robert P. Harrison,
....., 191..... Burial Permit Clerk Registrar.

MAY 19 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 18 1921, to May 19 1921, that I saw him alive on May 18 1921, and that death occurred, on the date stated above, at 0 A m.

The CAUSE OF DEATH* was as follows:

Premature birth due to
Uterine Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. J. Foster M. D.

May 19, 1921. (Address) 422 Rutland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, May 20, 1921

20-UNDERTAKER Chenoweth Son — ADDRESS Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53373 — 61 — D 53373

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera Apts ST.: 13 WARD)

2-FULL NAME Marion M. Kemper Rosenburg

(a) RESIDENCE. NO. Linden Ave & Lake Drive ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abel A. Rosenburg

6 DATE OF BIRTH (month, day, and year) Aug 27-1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimd.

PARENTS

10 NAME OF FATHER Isaac L. Kemper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss

12 MAIDEN NAME OF MOTHER Cora Krauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Abel A. Rosenburg. (Address) Lindenave & Lakedrive

15 Filed MAY 2 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1921, to May 18, 1921, that I last saw h[illegible] alive on May 15, 1921, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis (non epidemic)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Cerebro-Spinal Fever

(Signed) [illegible] M. D.

19 (Address) 1013 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew Cem	5/20 1921
20 UNDERTAKER	ADDRESS
David Sondheim	1180 N Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53874

CERTIFICATE OF DEATH.

120 D 53874

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 Portugal ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Auffarth

(a) RESIDENCE. NO. 2012 Portugal ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Auffarth

6 DATE OF BIRTH (month, day, and year) Oct 8, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Schiefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lenhausen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Simonsen

(Address) 2012 Portugal St

15 Filed MAY 20 1921 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to May 19, 1921, that I last saw h 2v alive on May 19, 1921, and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Oedema Lungs.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A L Tumbleson, M. D.

5/19, 1921 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL May 21 1921

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Filed St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53875

CERTIFICATE OF DEATH.

28 D 53875

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1329 N Carey ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Dowell

(a) RESIDENCE. No. 1329 Carey ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1916 - Jan 15th

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Robert Dowell

11 BIRTHPLACE OF FATHER (city or town) Essex Co
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ida Robinson

13 BIRTHPLACE OF MOTHER (city or town) Essex Co
(State or country) Virginia

14 Informant Robert Dowell
(Address) 1329 N Carey St

15 MAY 20 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-15-, 1921, to 5-18-, 1921, that I last saw h.. alive on 5-18-21, 19..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchitis & Tuberculosis Virginia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculosis Virginia

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W H Barkis, M. D.

May 18 1921 (Address) 1388 Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 20 1921
20 UNDERTAKER	ADDRESS
Samuel Kennedy	578 N Bond

Burial permit issued

MAY 20 1921

ROBERT E. LITTLE

Should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

14806 7. D 53876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109 D 53876

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas B. Groom.

(a) RESIDENCE. No. 722 N. Gay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced ~~HUSBAND OF~~ ~~(or WIFE OF)~~ ~~Emma C. Groom~~ ~~(State)~~

6 DATE OF BIRTH (month, day, and year) Oct. 8. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): O/J

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm. C. Groom

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Christiana Fueler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bata Co

14 Informant: Johns Hopkins Hospital Records.
(Address)

15 MAY 2 01921 ROBERT J. BLAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 18, 1921, that I last saw him alive on May 18, 1921, and that death occurred, on the date stated above, at 4.51 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

15 minutes
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Operation for hydrocele

Did an operation precede death? Yes Date of 5/3/21

Was there an autopsy? No

What test confirmed diagnosis? Typical findings

(Signed) Frederick M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 21st 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

...ions on back of certificates. ...statement of OCCUPA-

D 53877

Aloia Isak

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 324 S Bruce ..... St.: 19 156 WARD)

REGISTERED No. C D 53877

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aloisia Isak

(Residence in Baltimore: No. 324 S Bruce St.; (yrs. 14 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 29 (Day), 1870 (Year)

7-AGE, 51 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Hungary

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Hungary

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Isak

(Address) 324 S. Bruce

15- MAY 20 1921 CORONER'S CERTIFICATE

Filed ..... 191..... at ..... o'clock

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 18 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Asphyxiation by Illuminating Gas, Suicide

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

Duration ..... yrs. ..... mos. ..... ds.

(Signed) James M. Hundley M. D. (Coroner.)

May 19, 1921 (Address) 200 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral	May 21, 1921
20-UNDERTAKER	ADDRESS
Harry H. Witz Co	1531 W Lombard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53378

CERTIFICATE OF DEATH.

1920 D 53378

1-PLACE OF DEATH Union Memorial Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST.; 27 ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Hucke

(a) RESIDENCE. NO. 2 west Spring Ave ST., WARD. Raspburg, Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 19, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Messenger at Hutzler's

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER George E. Hucke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Christina Nagel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Geo. E. Hucke (Address) Raspburg Md

15 MAY 20 1921 ... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1921

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1921, to May 17, 1921, that I last saw her alive on May 17, 1921, and that death occurred, on the date stated above, at 7.05 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis -
Nephritis.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Uremia -
(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? Clinical

(Signed) J. W. Hinman Jr. M. D.

May 17, 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 20 1921
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic condition.
Endocarditis due to
nephritic condition.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53879 D 53879

CERTIFICATE OF DEATH.

REGISTERED NO. 102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin E. Kenney

(a) RESIDENCE. NO. 130 W Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Anna Kenney

6 DATE OF BIRTH (month, day, and year) June 5 1891

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
29	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Crane operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Globe Ship Bldg.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John W. Kenney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Anna Kenney
(Address) 130 W Mulberry St.

15 Filed MAY 20 1921 19 ROYLE J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1921

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1921, to May 19, 1921, that I last saw him alive on May 19, 1921, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ruptured Gastric ulcer

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-18-21

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Brownshad, M. D.

5-14-1921 (Address) St Jos Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Dallas	May 23 1921

20 UNDERTAKER Margaret G. Flynn ADDRESS 1722 Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53880 ✓ D 53880

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 E Barney ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — Cecilia E Kenny

(a) RESIDENCE. NO. 210 E Barney ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Joseph A Kenny

6 DATE OF BIRTH (month, day, and year) July 2/1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	53	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER — Owen McCall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER — Bessie McCall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Joseph A Kenny

(Address) 210 E Barney St

15 Filed MAY 20 1921 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to May 18, 1924, that I last saw h[illegible] alive on May 17, 1924, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C W Mallette M. D.

5/18, 1924 (Address) 1279 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 21, 1921

20 UNDERTAKER Margaret G. P Lynn ADDRESS 1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53881

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3204 Eastern Ave ST.: 76 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Taylor

(a) RESIDENCE. No. 3204 Eastern Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4th 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Alger Taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER [redacted]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Alger Taylor
(Address) 3204 Eastern Ave.

15 MAY 20 1921 ROBERT F. [illegible] Registrar

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17

I HEREBY CERTIFY, That I attended deceased from April 15 1921, to May 18 1921, that I last saw her alive on May 17, 1921, and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Date of -

Was there an autopsy? -

What test confirmed diagnosis? -

(Signed) Marshall L Mayer M. D.

, 19 (Address) 315 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkesley Va.	May 21 1921
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53382

CERTIFICATE OF DEATH.

175-001 D 53382

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nelson A Haslup.

(Residence in Baltimore: No. 1823 N Chapel St. St.; 9 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
M	W	Single

6-DATE OF BIRTH, July 2 1911, 1
(Month) (Day) (Year)

7-AGE, 9 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work NONE
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), D C

PARENTS.

10-NAME OF FATHER. Nelson J Haslup

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Elmyra Adams

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Trosset

(Address) 1442 N Gay St

15-

MAY 20 1921. 191.....

ROBERT A. CAUTHEN
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident
Fracture Skull.
(Duration) yrs. mos. 1 hr ds.

CONTRIBUTORY (Secondary) Shock.
(Duration) yrs. mos. ds.

(Signed) Geo Clinton Black M. D.
(Coroner.)

May 17 1921. (Address) 142 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, May 21, 1921.

20-UNDERTAKER Geo Trosset

ADDRESS 1442 N Gay St

CAUSES OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53883

D 53883

CERTIFICATE OF DEATH.

28-010

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2724 Hugo ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Jink

(a) RESIDENCE. No. 2724 Hugo ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 1895

7 AGE: Years 26 Months Days 13

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Edward Jink

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germ.

12 MAIDEN NAME OF MOTHER: Adeline Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germ

14 Informant: Charles Jink
(Address) 2724 Hugo ave

15 Filed MAY 20 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 19 21

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 19 21, to May 18, 19 21,

that I last saw him alive on May 17, 19 21,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pellagra

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H J Gotsch, M. D.

19, 19 (Address) 2724 Hugo ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 21 19

20 UNDERTAKER: Jos. J. Herr — ADDRESS: 156 N. Luzerne ave

TION is very important. See instructions on back of certificates.

Spec. 6-2-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53884

CERTIFICATE OF DEATH

91 D 53884

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bourne

(a) RESIDENCE. No. 92 Brick ore Rayburn ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Late John P. Bourne

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Edward Hercules

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Rosie Greis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Bay View Hospital Balto. Md.

15 MAY 20 1921 [illegible] Registrar

Burial [illegible] Olert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1921, to May 19, 1921, that I last saw h[illegible] alive on May 19, 1921, and that death occurred, on the date stated above, at 10 15 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumokoniosis Tuberculosis Pulmonis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) H. F. Edwards, M. D.

5/20/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 23, 1921
20 UNDERTAKER Henry Hoeck & Son	ADDRESS 1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form. (6-9-19—21 P. Co.—1000 Bks.

D 53885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53885

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S. 15th ST.; 26 WARD)

2-FULL NAME Isabella Rollison

(a) RESIDENCE. No. 410 S. 15th ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Rollison

6 DATE OF BIRTH (month, day, and year) Aug 2, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	76	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General natare of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emily Everett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John T. Rollison

(Address) 410 S. 15th St

MAY 2 01921

ROBERT J. BRAUNER

Registrar

Burial Permit Oleat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 19, 1921, to May 18, 1921, that I last saw h... alive on May 18, 1921, and that death occurred, on the date stated above, at 9:40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Kaufmann, M. D.

Jun. 19 21 (Address) 1035 Dodderidge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem't	May 21 1921
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Fred Hall

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53836

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53886

CERTIFICATE OF DEATH.

176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Hall

(a) RESIDENCE. No. 1749 Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Hall

6 DATE OF BIRTH (month, day, and year) Dec 28 - 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76 -	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Transfer Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant L. G. Hall

(Address) 1802 E. Oliver St

15 MAY 20 1921 ROBERT J. KRAUTZ Registrar

Burial Permit Oliver

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to May 19, 1921, that I last saw him alive on May 19, 1921, and that death occurred, on the date stated above, at 8. m.

The CAUSE OF DEATH* was as follows:

Acute Cystitis + acute Prostatitis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wallace, M. D.

May 19, 1921 (Address) # 22 Bentley

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	May 23 1921
20 UNDERTAKER	ADDRESS
Wm. Cahill	502 E. Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Tarleton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53887

CERTIFICATE OF DEATH.

D 53887

1-PLACE OF DEATH

REGISTERED NO. 1542

CITY OF BALTIMORE: (No. 1627 Fairmount St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ellen L. Tarleton

(a) RESIDENCE. NO. 1627 Fairmount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Tarleton

6 DATE OF BIRTH (month, day, and year) April 12 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joshua Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George E. Tarleton
(Address) 1627 Fairmount

15 Filed MAY 20 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to May 18, 1921, that I last saw her alive on May 18, 1921, and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) yrs. 10 mos. about ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Jewett, M. D.

, 19 (Address) 26 E Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 21 1921

20 UNDERTAKER Wm Cook — ADDRESS 502 E 4th

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 53883

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5107 York road ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Baynard

(a) RESIDENCE. No. 5107 York road ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~(or) WIFE~~ of Wm H. Baynard

6 DATE OF BIRTH (month, day, and year) Mar 25-48

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) York Balto Md

10 NAME OF FATHER Wm Gorsuch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant B. Harrison Baynard

(Address) 5107 York road

15 Filed MAY 20 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17

I HEREBY CERTIFY, That I attended deceased from May 16, 1921, to May 18, 1921.

that I last saw her alive on May 18, 1921.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Haemaphysa left side

PTER

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan, M. D.

, 19 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 21 1921
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53889

CERTIFICATE OF DEATH.

92. D 53

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Margaret Hopper

(a) RESIDENCE. NO. 1209 E. Federal ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Milton L. Hopper

6 DATE OF BIRTH (month, day, and year) Jan 16 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James A. Betts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Cecelia Betts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Milton L. Hopper (Address) 1209 E. Federal St.

15 Filed MAY 20 1921, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1921, to May 18, 1921, that I last saw her alive on May 18, 1921 and that death occurred, on the date stated above, at 3 30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. - mos. 12 hrs ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. C. Manning, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 21 1921
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... origin; "Cancer" is less definite; avoid use of "....." for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar

Spec.—6-9-19—H. P. Co.—1000 Bks.

Gestena Thomas

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53890

CERTIFICATE OF DEATH.

81 D 53890

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 N Broadway ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gestene Thomas

(a) RESIDENCE. No. 807 N Broadway ST., 7 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Thomas

6 DATE OF BIRTH (month, day, and year) May 8 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	—	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Nat Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry G Thomas
(Address) 807 N Broadway

15 Filed ....., 19.... Registrar

MAY 2 0 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1921

17 I HEREBY CERTIFY, That I attended deceased from May 6th 21, to May 19 21, that I last saw h[illegible] alive on May 18th 21, and that death occurred, on the date stated above, at 2.15 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Coma

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) S W Sykes, M. D.

(Address) 1504 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuels Cemetery	May 21 1921
20 UNDERTAKER	ADDRESS
Louis Heemann	32 S Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 53891

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 1/2 Greenmount ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Dozier

(a) RESIDENCE. No. 530 1/2 Greenmount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-8 80

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Mack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm Young (Address) 530 1/2 Greenmount Ave

15 Filed MAY 20 1921 ROBERT E. FRAZIER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to May 19, 1921, that I last saw her alive on May 19, 1921, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
Not known about
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) Samuel A Bani, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 21 1921
20 UNDERTAKER Daniel Earbon	ADDRESS 916 Pa ave

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53892

CERTIFICATE OF DEATH.

1417 D 53892

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C Gardiner

(a) RESIDENCE. NO. 539 Wolfshire ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant Berrie B Moody (Address)

15 Filed MAY 20 1921 ROBERT F KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to May 19, 1921, that I last saw him alive on May 19, 1921, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Oedema of Glottis (duration) 2 hrs.

CONTRIBUTORY (Secondary) Cellulitis (Cervical) (duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes no Date of 5/19/21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

, 19 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL May 22 1921

20 UNDERTAKER Daniel Cooke ADDRESS 916 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 53893

CERTIFICATE OF DEATH.

64 D 53893

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Mc Culloh ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Franklin Roberts

(a) RESIDENCE. NO. 1508 Mc Culloh ST., 14 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella V Roberts

6 DATE OF BIRTH (month, day, and year) 1875.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 921

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer John Smith

9 BIRTHPLACE (city or town) Cumberland
(State or country) Md

PARENTS

10 NAME OF FATHER Francis A. Roberts

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant James W. Smith
(Address) 915 N. Mc Culloh St.

15 Filed MAY 20 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 18, 1921, that I last saw him alive on May 18, 1921, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 8
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) S. T. Hyde M. D.

May 19 1921 (Address) 1413 E. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral bur	May 21 1921

20 UNDERTAKER Daniel Easton ADDRESS 916 Eas

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53894 ✓ D 53894

D 53894 CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. Mercy Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Thompson

(a) RESIDENCE. NO. 1703 St Paul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17 21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 400

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Frank Snow

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Thompson

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country) W. Va?

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 2 01921 ROBERT A KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1921

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1921, to May 17, 1921, that I last saw h... alive on May 11, 1921, and that death occurred, on the date stated above, at 930 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Francis I Kearney, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAY 20 1921, 19

20 UNDERTAKER

ADDRESS

Health Commissioner

SECTION is very important. See instructions on back of certificates. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53895

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 715 Brannan Court. ST. 22 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Thomas. (C)

(Residence in Baltimore: No. 715 Brannan Court. St.; yrs., 1 hour. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, May 19th. 1921., 1 (Month) (Day) (Year)

7-AGE. ~~Yrs.~~ ~~mos.~~ ~~ds.~~

If LESS than 1 day, 1 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 600
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Albert Thomas. (C)

11-BIRTHPLACE OF FATHER (State or Country), Charles Co. Md.

12-~~MAIDEN~~ NAME OF MOTHER Katie Wright. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Thomas. (C) father.

(Address) 715 Brannan Court.

15- Robert P. Harrison,

Filed ..... 191.....

MAY 20 1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency.
congenital.
(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)
(Duration) ...yrs...mos...ds.

(Signed) Albert Reinhardt M. D. (Coroner.)

May 19, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs...mos...ds. In the State ...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 19....
20-UNDERTAKER	ADDRESS
	MAY 20 1921

Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53896

CERTIFICATE OF DEATH.

175-00

1 PLACE OF DEATH CITY OF BALTIMORE (No. Mercy Hospital ST. 9 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Aloysius Kirby

(Residence in Baltimore: No. 2009 - Homewood Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE White

5-SINGLE, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH July 1, 1877 (Month) (Day) (Year)

7-AGE, 43 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Auditor
(b) General nature of industry, business, or establishment in which employed (or employer) Ballo Saw Paper Co

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Kirby

11-BIRTHPLACE OF FATHER (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER, Mary Fitzpatrick

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Sullivan

(Address) 2009 Homewood Ave.

15-

Robert P. Harrison,

Filed MAY 20 1921, 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH May 18, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto - Accident
Fracture Skull.
(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock.
(Duration) ? yrs. mos. ds.

(Signed) Fred Lothrop Blades M. D.
(Coroner.)

May 20 191. (Address) 1432 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral	May 21 1921
20-UNDERTAKER	ADDRESS
Hall Mem Son	505 N Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(J-Houston)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53897

D 53897

120

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Edmondson Ave. 16 WARD)

2-FULL NAME Mary H Houlton

(a) RESIDENCE. NO. 1102 Edmondson Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? 60 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced~~ (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Teacher 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Houston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie C. Rouse

(Address) 1102 Edmondson Ave

15 Filed MAY 20 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 21

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1921, to May 19 1921, that I last saw he alive on May 19th 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic Interstitial

(duration) 2 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of x

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) V. Van Williams M. D.

, 19 (Address) 1 E Centre St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 21 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	247 S. Mar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53898 ✓ D 53898

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 Mc Elderry ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Roland Riley

(a) RESIDENCE. No. 2219 Mc Elderry ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. 12 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced~~ (write the word)
Male	White	Baby

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) May 8-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Francis J. Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Sophie L. Limbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Francis J. Riley (Address) 2219 Mc Elderry St.

15 Filed May 20 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-19 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1921, to May 19, 1921, that I last saw h[illegible] alive on May 19, 1921, and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	May 21 1921
20 UNDERTAKER	ADDRESS
Jas C. Miller	2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53899

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Orleans St ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Ann Stammen

(a) RESIDENCE. No. 1435 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced
(or) WIFE of Charles G. Stammen

6 DATE OF BIRTH (month, day, and year) Nov. 28. 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Martin W. Mattee

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Shock

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co.
(State or country) Maryland

14 Informant Mrs A. Lapouraille (daughter)
(Address) 1435 Orleans St

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

Y 201921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March, 1917, to May 20, 1921, that I last saw her alive on May 19, 1921, and that death occurred, on the date stated above, at 2:15 Am.

The CAUSE OF DEATH* was as follows:

Acute Indigestion (duration) Four days mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy of heart about one year (duration) Several years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard C. Silver, M. D.

, 19 (Address) 3706 Liberty Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 22 1921
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53900

41

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph Hosp. ST.: 8 WARD)

2-FULL NAME Elizabeth J Cooper

(a) RESIDENCE. No. 1731 N. Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	M.

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of William Cooper

6 DATE OF BIRTH (month, day, and year) Aug-30-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) housework

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town) Balto, (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Hester Nicholls

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland.

14 Informant Dr William Cooper

(Address) 1731 N. Broadway.

~~Robert F. Harrison~~

MAY 20 1921 , 19

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21 to May 18, 1921, that I last saw h alive on May 18, 1921 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Intestines

(duration) yrs. 2 mos. 28 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? yes Date of

Was there an autopsy? no.

What test confirmed diagnosis? operation

(Signed) Frank C. Kearney, M. D.

May 18, 1921 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	May 21 1921
20 UNDERTAKER H E Stughes	ADDRESS 1st St. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53901

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1539 Hanover ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa M. Fable

(a) RESIDENCE. No. 1539 Hanover ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Fable

6 DATE OF BIRTH (month, day, and year) Aug 9th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work (d)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John P Fable

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Hauch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Fable
(Address) 1539 Hanover St

15 Filed Robert F. Harrison, Registrar

Y 201921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to May 19, 1924, that I last saw h[illegible] alive on May 16, 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows

Uremic Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Chronic Brights Disease

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Faulkner M. D.

5/20 1924 (Address) 1 E Read[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	May 21 1924
20 UNDERTAKER E Schloman Sons	ADDRESS 1034 Hanover St

...SE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53902

D 53902

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1162 McElderry ST.; 5 WARD)

2-FULL NAME Hugo Goldman Wheeler

(a) RESIDENCE. No. 1162 McElderry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) don't know

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7 month old		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city
(State or country)

PARENTS

10 NAME OF FATHER Albert Wheeler

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Fanny Attwood

13 BIRTHPLACE OF MOTHER (city or town) Pennsylv
(State or country)

14 Informant Fanny Wheeler 1162
(Address) Albert Wheeler 1162 McElderry

15 Robert F. Harrison, Registrar
MAY 21 1921 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20-1921

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to May 20, 1921, that I last saw h alive on May 20, 1921, and that death occurred, on the date stated above, at 3:35 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

(duration) yrs. 2 mos. weeks ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) A. A. Hornstein, M. D.

5/20, 1921 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Baltimore County	May 21 1921
20 UNDERTAKER	ADDRESS
D. Elmer B. Pyle	1022 Hanover

MAY 21 1921

IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53903 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53903

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317-East-30th-Street. ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Shoemaker Brawner

(a) RESIDENCE. NO. 317-E-30-Street. ST., 12 WARD. (Resident)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 77 yrs. 11 mos. 1 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Campbell Brawner

6 DATE OF BIRTH (month, day, and year) June-18-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Henry Ould

11 BIRTHPLACE OF FATHER (city or town) Charles Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth ???

13 BIRTHPLACE OF MOTHER (city or town) CharlesCo. (State or country) Maryland.

14 Informant Mr. M. R. Bailey (Grandson)

(Address) 317-E-30th-St., City.

15 Filed 21 1921 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1921

17 I HEREBY CERTIFY, That I attended deceased from April 6 1921 to May 19 1921, that I last saw h alive on May 17 1921, and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows: Duel cerebral Hemorrhage

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Symptoms & Autopsy

(Signed) [illegible] M. D.

5/20 1921 (Address) 2072 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May-21-21 19

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53904

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53904

CERTIFICATE OF DEATH.

X 108

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. St Joseph's Hosp. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine McCaffery

(a) RESIDENCE. NO. Towson (York Rd) ST., WARD. Towson Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 9-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Cockeysville
(State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER John Thos. McCaffrey.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Fredrick Co. Md.

12 MAIDEN NAME OF MOTHER M. T. Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Cockeysville
(State or country) Balto. Co. Md.

14 Informant Baby McCaffrey.
(Address) Towson

15 Filed MAY 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1921, to May 20, 1921, that I last saw h.er alive on May 20, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Acute Suppurative Appendicitis

(duration) ..... yrs. ..... mes. 6 ds.

CONTRIBUTORY (Secondary) Paralytic ileus

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of May 18, 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. McElwain, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph. Cem.	May 22 1921
20 UNDERTAKER	ADDRESS
J. Kay Burns Sons	Towson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53905

CERTIFICATE OF DEATH.

64 D 53905

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Elizabeth C. Hopkins

(a) RESIDENCE. No. 605 N. Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-7-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	10	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER Louis N. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland -

12 MAIDEN NAME OF MOTHER Lucy T. Brafton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Louis N. Hopkins
(Address) 605 N. Charles St

15 Filed Robert P. Harrison, Registrar
2-1 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1921, to May 19, 1921, that I last saw her alive on May 19, 1921, and that death occurred, on the date stated above, at 8.54 P. m.

The CAUSE OF DEATH* was as follows:
Chronic nephritis.
Hypertension.

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage -

(duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? Clinical -

(Signed) J. M. Hurney, M. D.

May 19th 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	4-21 1921
20 UNDERTAKER	ADDRESS
Wm. Geo. Eakin & Son Co	
McCulloh & Archard	

TION is very important. See instructions on back of certificates.

Spec. 6-3-19—H. P. Co.—1000 Bks.

14524/
D 53906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53906

CERTIFICATE OF DEATH.

55,001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Taylor.

(a) RESIDENCE. No. 1616 Jefferson St. ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 20. 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thos Taylor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Libbie Tate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed . 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17

I HEREBY CERTIFY, That I attended deceased from May 17. 1921. to May 20. 1921.

that I last saw h alive on May 20. 1921.

and that death occurred, on the date stated above, at 2 35 a m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W P Harrison, M. D.

5-20. 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Rich Mond Co Va	May 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5 21 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53907 D 53907

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hosp

CITY OF BALTIMORE: (No. ..... ST.: 25 WARD) 109

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Robertson

(a) RESIDENCE. NO. Spring Grove Insane ST. Asylum

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Wh

5 Single, Married, Widowed or Divorced (write the word) (Widowed)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Robertson

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE 48 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Male Attendant

(b) General nature of industry, business, or establishment in which employed (or employer) At Hosp for Insane

(c) Name of Spring Grove Ins. Asyl.

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Isabel Kinhard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant James Robertson

(Address) Spring Grove Ins. Asyl.

15 1921 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-21-21

17 I HEREBY CERTIFY, That I attended deceased from 10 pm 5-20-21 19..., to 4.50 am 5-21-21, that I last saw him alive on 5-21-21 19..., and that death occurred, on the date stated above, at 4.50 am m.

The CAUSE OF DEATH* was as follows:

Volvulus of Intestines.

Gangrene of Intestines

(duration) yrs. mos. 20 hrs.

CONTRIBUTORY (Secondary) Toxemia - Cardiac Failure (duration) yrs. 20 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-20-21 11 pm

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) W. H. McCrady M. D.

19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 24 1921
20 UNDERTAKER John J. Cowan & Son	ADDRESS 901 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53908 ✓ D 53908

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Coleman

(a) RESIDENCE. No. 4 Wylie Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Chas Coleman

6 DATE OF BIRTH (month, day, and year) [illegible] 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 466

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Mrs Harry J Schafer

(Address) 4 W. Wylie Ave

15 Filed MAY 21 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1921

17 I HEREBY CERTIFY, That I attended deceased from 4-3, 1921, to 5-18, 1921, that I last saw h[illegible] alive on 5-18, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophied prostate
Uremic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia due to post operative anuria (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 5-14-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W McKelvey M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 23rd 1921
20 UNDERTAKER John J Cowan Jr	ADDRESS 901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53909

CERTIFICATE OF DEATH.

1491

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Mosher ST.: 14 WARD)

2-FULL NAME. William Imes

(a) RESIDENCE. No. 702 Mosher St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Gaines

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of Industry, business, or establishment in which employed (or employer) Apron Factory

(c) Name of employer Katzenberg.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Elisha Imes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Emma Peck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Elisha Imes (Address) 702 Mosher St.

15 Filed MAY 21 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20 1921

17 I HEREBY CERTIFY, That I attended deceased from 3-30, 1921, to 5-19, 1921, that I last saw him alive on 5-19, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

(duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) William A. Harris, M. D.

, 19 (Address) 1200 Pima Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pine Lawn Cemetery	May 21 1921
20 UNDERTAKER	ADDRESS
John H Owens	5-38 Walbrook St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement should be stated EXACTLY. PHYSICIANS should be careful. AGE should be carefully supplied. AGE

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53910 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 53910

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Hoefer

(a) RESIDENCE. No. 145 Gay st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter - bartender

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 047

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER J. Gustav Otto Hoefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Agnes Wupner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address) M.T.H.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to May 18, 1921, that I last saw him alive on May 18, 1921, and that death occurred, on the date stated above, at 6.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. Kilgney, M. D.

5-19-21. (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	May 20 1921
20 UNDERTAKER George J Smith	ADDRESS 1000 E. Fayette st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53911

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1610 W. Mulberry St. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Martha Green

(a) RESIDENCE. No. 1610 W. Mulberry St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henson Green

6 DATE OF BIRTH (month, day, and year) 12/25/1855

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	4 5	13	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) Worked at home

(c) Name of employer Herself

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Lundon Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Priscilla Scyles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Md.

14 Informant Matilda Banks
(Address) 1618 W. Mulberry St

15 Filed MAY 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th. 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 19 21, to May 19th. 1921, that I last saw her alive on May 19th. 1921, 19, and that death occurred, on the date stated above, at 11:25 a.m.

The CAUSE OF DEATH* was as follows:

Aortic Insuffiency

(duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At res

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Exam.

(Signed) Walter J. Jackson, M. D.

5/20 1921 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olive Calvert Co	May 22nd 1921
20 UNDERTAKER	ADDRESS
Saml N. Chase & Son	1400 Mosher

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53912

CERTIFICATE OF DEATH.

D 53912

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Vincent's Infant Asylum ST. 14 + 37 WARD)

2-FULL NAME Mary Starr

(a) RESIDENCE. NO. St. Vincent's Infant Asylum ST. ..... WARD. Catonsville Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? yrs. 1 mos. 16 ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 3, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer .....

9 BIRTHPLACE (city or town) Catonsville
(State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Mary Starr

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant ..... (Address) Sr. W. Matthews St. Vincent's Infant Asylum

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

MAY 21 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 19 21

17 I HEREBY CERTIFY, That I attended deceased from Mar. 26, 19 21, to May 16, 19 21,
that I last saw her alive on May 16, 19 21,
and that death occurred, on the date stated above, at 6 p. m.
The CAUSE OF DEATH* was as follows:

Congental Syphilis

(duration) yrs. 2 mos. 13 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Haulee M. D.

MAY 18 1921 (Address) 1502 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 21 1921
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	827 W Balto

Spec.—8-24-14—M. & T.—2000 Blks.

D 53913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53913

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

REGISTERED NO. C 30

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Altamont Moses

(Residence in Baltimore: No. Sumter, S. C. St.; ..... yrs., ... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 13, 1914.
(Month) (Day) (Year)

7-AGE, 7 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Sumter S.C. America

PARENTS.

10-NAME OF FATHER, Henry Moses

11-BIRTHPLACE OF FATHER (State or Country), Sumter S.C.

12-MAIDEN NAME OF MOTHER Charlotte Emanuel

13-BIRTHPLACE OF MOTHER (State or Country), St Augustine Fla

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Moses

(Address) Sumter S.C.

15-

Filed ..... 21 1921 Robert H. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1921, to May 20th. 1921, that I saw him alive on May 20th. 1921, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... D. Zinberg ..... M. D.

5/20/21, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sumter S. C. DATE OF BURIAL, 5-21-, 1921

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Balto St

important. See instructions on back of certificate. ... very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53914

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53914

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1824 E. Fairmont Ave. ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Goffiel

(a) RESIDENCE. No 1824 E Fairmont ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael Goffiel

6 DATE OF BIRTH (month, day, and year) 1821

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	100	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 E Baltimore St.

15 Filed MAY 21 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. ..., 1921, to May 15th, 1921, that I last saw h.... alive on May 15th, 1921, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
" Liver,
(Carcinomatosis)

(duration) yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) H. A. Michelson, M. D.

, 19 (Address) 1420 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	5/22 1921
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53915

CERTIFICATE OF DEATH.

+ 53

D 53915

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Hyatt

(Residence in Baltimore: No. Annapolis, Md. St. ' yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 15, 1848 (Month) (Day) (Year)

7-AGE, 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Baltd St

15-

Filed MAY 21 1921, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20th, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 26th, 1920, to May 20th, 1921, that I saw h[e] alive on May 20th 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease with Bone involvement

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) 2 Kinberg M. D.

5/21/21, 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 8 mos. ds. In the State 13 yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Annapolis Md

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 5/22, 1921

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Baltd St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53916

CERTIFICATE OF DEATH.

92

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3524 Park Heights Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Fleischer

(a) RESIDENCE. No. 3524 Park Heights Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Bessie Fleischer

6 DATE OF BIRTH (month, day, and year) Aug 31-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Julius Fleischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Carrie Kable

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Sister Bessie Fleischer

(Address) 3524 Park Heights Ave

15 Filed MAY 21 1921, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to May 20, 1921, that I last saw him alive on May 20, 1921, and that death occurred, on the date stated above, at 6.20 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 8 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B M Bernardt, M. D.

5/20. 1921 (Address) 3447 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew Cem	5/22 1921
20 UNDERTAKER	ADDRESS
David Sondheim	118 West Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53917

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 53917

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 Myrtle ave ST.: 17 WARD)

2-FULL NAME James H. Larkins Sr.

(a) RESIDENCE. No. 1229 Myrtle ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maya. Larkins

6 DATE OF BIRTH (month, day, and year) Jan. 28-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Merchandise

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant (Address) James H. Larkins Jr 1229 myrtle ave

15 Filed MAY 21 1921, 19 Robert R. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 17th, 1921, to May 20th, 1921, that I last saw h[illegible] alive on May 18th, 1921, and that death occurred, on the date stated above, at 7.15 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Garrison Mart[illegible] M. D.

5-20 1921 (Address) 901 Myrtle Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents Cem	5/23" 1921

20 UNDERTAKER Chas F. Evans & Son ADDRESS 1180 W Mt Royal ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53918 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53918

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 671 Vine ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Dansill

(Residence in Baltimore: No. 671 Vine St.; ? yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ... (Month) — (Day) — , 1857 (Year)

7-AGE,	If LESS than 1 day,
70 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laundress 041
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Donnell

(Address) 671 Vine St

15-

Filed MAY 21 1921, 191...

Robert P. Harrison,
Burial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19th, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 18 1921, to May 19th 1921, that I saw her alive on May 18th 1921, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

.....

.....

(a) Angina Pectoris (Duration) ... yrs. — mos. One ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

..... (Duration) ... yrs. ... mos. One ds.

(Signed) Edward Gilbertson M. D.

May 20th, 1921. (Address) 1332 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	May 21, 1921
20-UNDERTAKER Samuel A. Newsom	ADDRESS 378 N. Eutaw

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53919

CERTIFICATE OF DEATH.

82-09b 53919

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View WARD 26)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Leisure

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 60				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.
5 21 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1921, to May 18, 1921, that I last saw her alive on May 18, 1921, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis; old cerebral thrombosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) B Heerman M. D.

5/13/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	May 20, 21
20 UNDERTAKER	ADDRESS
Samuel V Newby	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D 53920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. [illegible] ST. [illegible] WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME [illegible]

(Residence in Baltimore: No. Petersburg Va St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	W.	Single

6-DATE OF BIRTH, Unknown, 1891
(Month) (Day) (Year)

7-AGE. About 30 yrs. ..yrs..mos..ds. If LESS than 1 day, ..hrs. or..min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 087

9-BIRTHPLACE, (State or Country), Petersburg Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Nitwitter

(Address) Coly Morgue

15- Robert F. Harrison,

Filed ....., 191.....

5-21 1921 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

Sudden (Duration) ..yrs..mos..ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..yrs..mos..ds.

(Signed) [illegible] M. D.
(Coroner.)

May 21 1921 (Address) 1629 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs..mos..ds. In the State 1/2 hr. ..yrs..mos..ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Petersburg Va	May [illegible] 1921
20-UNDERTAKER Harrison & Hendley	ADDRESS 575 W Bdle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D 53921

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53921

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 N. Carrollton Av. WARD 18)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Drue Tribble

(a) RESIDENCE NO. 330 N. Carrollton Av. WARD 18
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1854

7 AGE: Years 65 | Months 5 | Days 5 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED: none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) — 900

(c) Name of employer —

9 BIRTHPLACE (city or town) Essex Co.
(State or country) Va.

PARENTS

10 NAME OF FATHER Peter S. Tribble

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy C. Muse

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Va.

14 Informant Peter S. Tribble
(Address) 330 N. Carrollton Av.

15 Filed MAY 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1921, to May 20, 1921.

that I last saw her alive on May 20, 1921.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart disease

(duration) 4 yrs. — mos — ds

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Martin F. Cloran M. D.

5.21. 1921 (Address) 414 Prof. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lebanon Cemetery Essex Co Va. — DATE OF BURIAL: May 23 1921

20 UNDERTAKER: George J. Smith — ADDRESS: 1005 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53922 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 53922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 14 WARD) REGISTERED NO. 108

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Robert Tarbet

(a) RESIDENCE. NO. Whitefords Md. ST., WARD. Whitefords Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Robert Tarbet

6 DATE OF BIRTH (month, day, and year) Oct 1, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Tarbet.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp. Record.
(Address)

15 Filed MAY 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17

I HEREBY CERTIFY, That I attended deceased from May 18, 1921, to May 21, 1921, that I last saw h[illegible] alive on May 21, 1921, and that death occurred, on the date stated above, at 1.40 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Pneumonia (Bronchial)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 18, 1921

Was there an autopsy?

What test confirmed diagnosis? Operation & Clinical

(Signed) [illegible], M. D.

May 21, 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dawn Grove Pa	5-21 1921
20 UNDERTAKER	ADDRESS
E & B Hasle	115 E Hoffman

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Supposedly due to ruptured appendix. Exploratory operation but appendix never found.

Spec.—6-9-19—H. P. Co.—1000 Bks.

148293 D 53923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53923

CERTIFICATE OF DEATH.

30

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lang

(a) RESIDENCE. NO. 541 E. Fort ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Lang.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed MAY 21 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to May 20, 1921, that I last saw h[illegible] alive on May 20, 1921, and that death occurred, on the date stated above, at 4½ A m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? lumbar puncture

(Signed) W Davison, M. D.

5-23, 1921 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	5/21/1921
20 UNDERTAKER	ADDRESS
[illegible]	318 Cathedral

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53924 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 53924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH B. & O. R. R. tracks — REGISTERED NO. C 24 162

CITY OF BALTIMORE (No. Foot of Cooksie St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J. F. Cook.

(Residence in Baltimore: No. 1361 Andre St. 40 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Widower.

6-DATE OF BIRTH, August 10th, 1866., 1 (Month) (Day) (Year)

7-AGE, 54 yrs. 9 mos. 7 ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Martinsburg W. Va.

PARENTS.

10-NAME OF FATHER, William K. Cook.

11-BIRTHPLACE OF FATHER (State or Country). Pittsburg, Pa.

12-MAIDEN NAME OF MOTHER Mary A. Shank.

13-BIRTHPLACE OF MOTHER (State or Country), Berkley Springs, W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah E. Frances. (sister)

(Address) 604 Maryland Ave. Brooklyn.

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MAY 21 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide.

Decobitated, run over by car 44744 at the B. & O. R. R. Co.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto Reinhardt M. D. (Coroner.)

May 19., 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
CEDAR HILL.	MAY 21 1921, 19....

20-UNDERTAKER	ADDRESS
JOHN F. KINNY	713 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Audrey C. Henry)

D 53925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53925

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N. Kenwood St.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey Catherine Henry

(a) RESIDENCE. No. 518 N Kenwood ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/19/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Howard Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Ethel Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Howard Henry 518 N. Kenwood.

15 Filed MAY 21 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20 19 20

17 I HEREBY CERTIFY, That I attended deceased from May 19, 19 20, to May 20, 19 20, that I last saw h[illegible] alive on May 20, 19 20, and that death occurred, on the date stated above, at 8-10 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia Livida

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Childbirth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) C K Meyer Jr M. D.

5/21, 19 20 (Address) 1638 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK	MAY 21 1921
20 UNDERTAKER	**ADDRESS**
JOHN F. DENNY	715 LIGHT ST.

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53926

CERTIFICATE OF DEATH.

D 53926

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Paca St. Mt. Winans ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Simmons

(Residence in Baltimore: No. 2 Paca St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	C	child

6-DATE OF BIRTH, 5 (Month) 12 (Day), 1921 (Year)

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 7 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Richard Simmons

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Rose Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard R Simmons

(Address) 2 Paca St Mt Winans

15-

Filed ..... 191.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5-12 1921, to 5-18 1921, that I saw him alive on 5-18 1921, and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

7 months baby

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion Marasmus

..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) W B Hale M. D.

5-24, 1921 (Address) Haleithorp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	May 21, 1921
20-UNDERTAKER	ADDRESS
Edw Ruggold	1463 Carey

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53927 D 53927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N. Mount ST.: 16 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gideon Elsworth Booze

(a) RESIDENCE. No. 1037 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Elizabeth Booze

6 DATE OF BIRTH (month, day, and year) Oct. 2-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53			

8 OCCUPATION OF DEACESED Laborer

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Day labor

(c) Name of employer Cumberland Sterling Co.

9 BIRTHPLACE (city or town) Frederick Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Elijah Booze

11 BIRTHPLACE OF FATHER (city or town) Frederick Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine Ponner

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co. (State or country) Md.

14 Informant Mary Elizabeth Booze (Address) 1037 N. Mount St.

15 Filed MAY 21 1921 Robert P. Harrison, Registrar (Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2- 1921, to May 19- 1921, that I last saw him alive on May 19- 1921, and that death occurred, on the date stated above, at 1-17 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis (duration) about one yr. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Course

(Signed) Chas. L. McCarty, M. D.

, 19 (Address) 906 N. Strieker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 23 1921
20 UNDERTAKER	ADDRESS
Edw. Ringgold	1463 Carey

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

= Jozefa Knjwa :

D 53928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53928

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1720 Aliceanna ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gozefa Knjawa

(a) RESIDENCE. NO. 1720 Aliceanna ST., 2" WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 29 yrs. 0 mos. 0 ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4918 11.30

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanislaus Knjawa.

6 DATE OF BIRTH (month, day, and year) Unknown 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work at home.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Stanislaus Kszewnski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Cicrlia Majchork.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Stanislaus Knjwa.

(Address) 1720 Aliceanna St.

15 FILED MAY 22 1921 SOBER & BEATTY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21 1921

17

I HEREBY CERTIFY, That I attended deceased from 5/20, 1921, to 5/20, 1921, that I last saw h[illegible] alive on 5/20, 19..., and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

OVER

(Corrected)

Bronchio Pneumonia

(duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) Heart failure & Collapse

(duration) ...yrs. ...mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Thos A Bullock, M. D.

5/24/1921 (Address) 7th A Bullock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem.

DATE OF BURIAL: 1921

20 UNDERTAKER: M. F. Sudowski.

ADDRESS: 1705 S. Ann St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cancer of liver.

D 53929

Spec.—6-9-19—H. P. Co.—1000 Blks.

53929 HEALTH DEPARTMENT—CITY OF BALTIMORE 53929 D 53929

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1348 N Monroe St. 13 WARD)

2-FULL NAME Harry E. Duelty

(a) RESIDENCE. No. 1348 N North Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Nathan Duelty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md

12 MAIDEN NAME OF MOTHER Sarah Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Md.

14 Informant Mrs Sarah Duelty
(Address) 1348 N North Ave

15 Filed . 19 ROBERT J. KRAUTH Registrar
MAY 22 1921 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1921, to May 21, 1921, that I last saw him alive on May 21, 1921, and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Brights (Chronic Nephritis)

(duration) Not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilitation of Heart & pulmonary Weakness 30 ds.
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Carr Co. Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) E. H. Smith, M. D.

5/24 1921 (Address) 1605 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Marion Town Md	May 24 1921
20 UNDERTAKER	ADDRESS
Josiah Syfer & Son	North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 53930 Howard Jones

CERTIFICATE OF DEATH.

45 D 53930

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 State ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Jones

(Residence in Baltimore: No. 335 State St.; 20 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH. ..... November ....., 1 .....
(Month) (Day) (Year)

7-AGE. 60 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Coal Carrier
(b) General nature of industry, business, or establishment in which employed (or employer)..... 035

9-BIRTHPLACE, (State or Country). Living in Baltimore 16 Years
Preston Md Eastern Shore

PARENTS.

10-NAME OF FATHER. Jenkins Jones

11-BIRTHPLACE OF FATHER (State or Country) born in Dorchester Co.

12-MAIDEN NAME OF MOTHER Sarah Jane Butler

13-BIRTHPLACE OF MOTHER (State or Country). Caroline Co Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) by Sarah Jones

(Address) Live in Preston Md.

15- MAY 22 1921 Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 18, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 1914, to May 15 1921, that I saw h... alive on May 15 1921, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

..... (Duration) ..4.. yrs. ..... mos. ..... ds.

CONTRIBUTORY, (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

May 19, 1921 (Address) 211 N Pine St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery

DATE OF BURIAL. May 22 1921

20-UNDERTAKER Mrs Charles B Jones

ADDRESS 211 N Pine St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53931

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53931

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Bond ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ahnaier Goren

(a) RESIDENCE. No. 107 S. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? 15 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Moses A. Goren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant L. Goren
(Address) 1127 West Woodard

15 Filed MAY 22 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17 I HEREBY CERTIFY, That I attended deceased from April 13th, 1921, to May 20th, 1921, that I last saw him alive on May 17th, 1921, and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Weiner, M. D.

5-21, 1921 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	May 22 1921
20 UNDERTAKER M. Goldberg	ADDRESS 127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53932 D 53932

CERTIFICATE OF DEATH.

157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 938 N. Gay (St.:) 10 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Jones

(a) RESIDENCE. NO. 938 N. Gay St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5. 21. 21.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry S. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Augusta Ga.

12 MAIDEN NAME OF MOTHER Mattie L. Hollandsclade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Henry S. Jones
(Address) 938 N. Gay St.

15 Filed MAY 22 1921 19 ROBERT J. KRAUTER Registrar
Burial ... Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) S. 21. 1921.

17 I HEREBY CERTIFY, That I attended deceased from May 21st, 1921, to May 21st, 1921,
that I last saw him alive on May 21st, 1921,
and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Debility
Premature Birth
6½ months

(duration) ... yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Placenta Previae Partialis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Hobbs H. A. Meyer, M. D.

May 21 1921 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 23 1921
20 UNDERTAKER	ADDRESS
J. Henry Lutz	1007 N. Bond

IMPORTANT—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53933

91

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 831 Cloney St ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernice Cahler St. 1 yrs., 3 mos. 22 ds.)

(Residence in Baltimore: No. 831 cloney st.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan (Month) 29 (Day), 1920 (Year)

7-AGE, 1 yrs. 3 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(h) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Bath city

PARENTS.

10-NAME OF FATHER, albert Carter

11-BIRTHPLACE OF FATHER (State or Country), Bath City

12-MAIDEN NAME OF MOTHER Blanche Hinds

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Carter

(Address) 831 Cloney st

15- Filed MAY 22 1921, 191... ROBERT J. ILLUTE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 (Month) 21 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) .....yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) H K Gorman M. D. (Coroner.)

5/21, 1921. (Address) 117 W Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, W W Lutheran

DATE OF BURIAL, May 22, 1921

20-UNDERTAKER Brown & Copland

ADDRESS 114 N. Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53934

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 53934

CERTIFICATE OF DEATH

REGISTERED NO. C 28

1-PLACE OF DEATH 1822 E. Monument Dr

CITY OF BALTIMORE (No. 1822 E. Monument ST.; 7 WARD)

2-FULL NAME Donnel E. Yerby Jr.

(Residence in Baltimore: No. 1822 E Monument Dr St.; 15 yrs. mos. ds.)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Nov (Month) 15 (Day), 1878 (Year)

7-AGE: 42 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Trucker 045
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Md

PARENTS

10-NAME OF FATHER: David E. Yerby

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Louisa Clark

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John G Benford

(Address) 1822 Monument St

15- Filed MAY 22 1921 191 SCOPED ! INDEXED Burial C. S. Register

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept in 1918, to May 1921.

that I saw him alive on May 19, 1921.

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs and larynx

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Insanity (Duration) 3 yrs. mos. ds.

(Signed) Bernard Daniel Bruce M. D.

May 20, 1921. (Address) 1037 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: May 23, 1921

20-UNDERTAKER: William G Schaeffer — ADDRESS: 1816 Monument

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 53935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 53935

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1417 E. Madison St. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Handler

(Residence in Baltimore: No. 1417 E. Madison St St.: 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Nov. 11 ....., 1882
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
38 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Agent
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dealer

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Louis Handler

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Minnie ——

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Leurs aka Handler

(Address) 1417 E. Mad St

15- MAY 22 1921 ROBERT F. KRAUTER

Filed....., 191..... Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May 20 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

5-21-, 191.. (Address) 19 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Workmen Circle	May 22, 1921
20-UNDERTAKER	ADDRESS
Jack Leurs	1417 E. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53936

CERTIFICATE OF DEATH.

175-001 D 53936

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hospital Hospital St.: 70 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Dunn,

(Residence in Baltimore: No. 2041 Stallings St.) St.; yrs., 39 mos. 8 ds.) 6

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH September 12, 1881
(Month) (Day) (Year)

7-AGE, 39 yrs. 8 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bookbinder 064
(b) General nature of industry, business, or establishment in which employed (or employer): Mfg. Stationers

9-BIRTHPLACE. (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Edward P. Dunn

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER Julia Fagan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Dunn,

(Address) 2041 Stallings St

15-

Filed MAY 22 1921, 191.... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Mon 16, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, May 23, 1921.

20-UNDERTAKER E. N. Offutt, Jr.

ADDRESS 324 E. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53937

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53937

CERTIFICATE OF DEATH.

8104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2005 Mc Henry St ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Elmer Leister

(a) RESIDENCE. NO. 2005 Mc Henry St ST., ... WARD. ...

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2 - 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 100

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George A. Leister,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Cath. A. Gilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant George A. Leister, (Address) 2005 Mc Henry St.

15 Filed MAY 22 1921 ROBERT J. BAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21. 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 19 21, to May 21, 19 21, that I last saw h[illegible] alive on May 21, 19 ..., and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of Liver

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) [illegible], M. D.

, 19 (Address) 543 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 23 1921
20 UNDERTAKER	ADDRESS
F. M. Offutt, Jr.	322 E. Lyon St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE ✓

D 53938

CERTIFICATE OF DEATH.

79 D 53938

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 261 Robert ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mariana Griffith

(a) RESIDENCE. No. 261 Robert ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Frisby Griffith

6 DATE OF BIRTH (month, day, and year): Aug. 2, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Denton, Caroline Co. Maryland

PARENTS

10 NAME OF FATHER: William Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Susan A. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Miss Frances M. Briscoe
(Address): 261 Robert Street

15 Filed MAY 22 1921 19 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Mch 15th 1921, to May 20th 1921, that I last saw h.. alive on May 19th 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Dilated Heart - causing oedema of the lungs -

(duration) - yrs. 2 mos. - ds.

CONTRIBUTORY (Secondary): Mitral Heart leak

(duration) 7 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of None

Was there an autopsy? None

What test confirmed diagnosis? auscultation

(Signed) Eugene Douglas M. D.

May 21. 1921 (Address) 820 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	5/23 19 1
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

148292 ~~148329~~ X30 D 53939

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Kapiloff

(a) RESIDENCE. No. 702 A. North 6th St Richmond, Va ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced ~~HUSBAND~~ (or) ~~WIFE~~ of David + Bella Kapiloff same address

6 DATE OF BIRTH (month, day, and year) May 18, 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 0. ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER David Kapiloff

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York City

12 MAIDEN NAME OF MOTHER Bella Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York City

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed MAY 22 1921 ROBERT F. CHUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to May 22, 1921, that I last saw her alive on May 22, 1921, and that death occurred, on the date stated above, at 2.10 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) ... yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Lumbar puncture

(Signed) W. H. Davison, M. D.

, 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va MAY	22 1921 19

20 UNDERTAKER Jack Lewis 1411 E. Balto. ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53940

D 53940

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 725 S Regester ST.; 2 WARD)

2-FULL NAME Frank Kriska

(a) RESIDENCE. NO. 725 Register st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Centonie Kriska

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Mates Kriska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Marie Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Centonie Kriska

(Address) 725 S Regester

15 MAY 22 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1921, to May 20, 1924

that I last saw him alive on May 19, 1924,

and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Hypertension (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? pending

(Signed) T T Rebecca, M. D.

5-20-24 (Address) 800 N Dallas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 23 1924

20 UNDERTAKER Paul Crockett — ADDRESS 1906 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53941

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N Bruce St ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick J. Ellis

(a) RESIDENCE. No. 811 N Bruce St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Ellis

6 DATE OF BIRTH (month, day, and year) May 15 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 186

(b) General nature of industry, business, or establishment in which employed (or employer) firing steam heating plant

(c) Name of employer City of Balto. (Electric Light)

9 BIRTHPLACE (city or town) (State or country) Dublin, Ireland

PARENTS

10 NAME OF FATHER William Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Co. Kirkdown Ireland

12 MAIDEN NAME OF MOTHER Mary Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Co. Wicklow Ireland

14 Informant P. J. Ellis Jr.

(Address) 1408 Pennsylvania Ave.

15 FILED MAY 22 1921 ROBERT F. BRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 19.. to May 20th 1921.

that I last saw h alive on May 20th 1921.

and that death occurred, on the date stated above, at 8:50 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy O'Hollaren M. D.

(Address) 400 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL May 23 1921

20 UNDERTAKER Margaret D. Flynn ADDRESS 1711 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53942

CERTIFICATE OF DEATH.

91 D 53942

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 Roslyn Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Adler

(a) RESIDENCE. No. 2310 Roslyn ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 9 mos. 20 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L. Adler

6 DATE OF BIRTH (month, day, and year) July 30 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Martin Engelbrecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry L. Adler
(Address) 2310 Roslyn ave

15 Filed MAY 23 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-15- 1921, to 5-20- 1921, that I last saw h[illegible] alive on 5-20- 1921, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) Harry Goldberg M. D.

5/21/1921 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 23 1921
20 UNDERTAKER	ADDRESS
W. Allen Fuller	3517 Springdale ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

1

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53943 ✓

D 53943

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2031 Eutaw Place ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. H. Stineman

(a) RESIDENCE. No. 2031 Eutaw Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan S. Stineman

6 DATE OF BIRTH (month, day, and year) April 22 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bedford Co Penna

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Arthur Wegefarth

(Address) 2031 Eutaw Place

15 Filed ..... 19 .....

MAY 23 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 22 May 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1920, to 22 May 1921, that I last saw him alive on 21 May 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) - yrs. 6 mos. - ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of -

Was there an autopsy? no

What test confirmed diagnosis? X-Ray & fluoroscopic

(Signed) Horace W. Byers, M. D.

19 (Address) 749 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 24 1921

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53944

CERTIFICATE OF DEATH.

28 D 53944

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lebena Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Frey

(Residence in Baltimore: No. Lebena Ave Nr Washington St.; / yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Aug (Month) 24 (Day), 1903 (Year)

7-AGE, 17 yrs. 8 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 600

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas. Frey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Martha Hudson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Frey

(Address) Mt Washington

15- MAY 23 1921 Filed..... 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 (Month) 19 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1920, to May 19 1921, that I saw her alive on May 18 1921, and that death occurred, on the date stated above, at 3.10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis — followed by

Exhaustion & heart failure

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) C. H. Benton M. D.

5-19..., 1921. (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge DATE OF BURIAL, May 23 1921

20-UNDERTAKER H. S. Marshall ADDRESS 539 Fulton Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 ✓ D 53945

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Ashland ave ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

9 30 a m

2-FULL NAME Elizabeth Ingram Mason

(a) RESIDENCE. No. 1406 Ashland ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward H. Mason

6 DATE OF BIRTH (month, day, and year) July 5. 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Ingram

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Edmondson

13 BIRTHPLACE OF MOTHER (city or town) Pittsburg
(State or country) Pennsylvania

14 Informant William R. Mason
(Address) 1406 Ashland ave

15 Filed MAY 23 1921 NOTED AND AUDITED Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15 , 1921 to May 20 , 1921, that I last saw her alive on May 20 , 1921, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos L Young M. D.

, 19 (Address) 1107 Symington Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 23 1921

20 UNDERTAKER ADDRESS

John B. Spence. 1325 N Caroline St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53946

CERTIFICATE OF DEATH.

H1 ✓D 53946

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gilmor Hoffman Jr.

(a) RESIDENCE. No. 1203 Cathedral St., WARD. 11
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 8 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Wm G. Hoffman Jr.

6 DATE OF BIRTH (month, day, and year) 1861 - 9 - 8

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Business man. of h

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William G. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Wm Gilmor Hoffman
(Address) 1203 Cathedral St

15 Filed MAY 23 1921 19 ROBERT F. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1921

17

I HEREBY CERTIFY, That I attended deceased from May 15th, 1921, to May 21st, 1921, that I last saw him alive on May 21st, 1921, and that death occurred, on the date stated above, at 3 15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ileo-caecal Valve

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia, rt; oedema of lungs. 2½ mos; terminal.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes. Date of May 14th, 1921

Was there an autopsy? no.

What test confirmed diagnosis? Operation.

(Signed) J. W. Kinney Jr., M. D.

May 21, 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	May 23 1921
20 UNDERTAKER	ADDRESS
Henry A. Jenkins Sons	McCulloh + Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—3-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53947

CERTIFICATE OF DEATH.

D 53947

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 38 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Dunkinson

(a) RESIDENCE. No. Plainfield N. J. ST., WARD. Plainfield N. J.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Wm H. Dunkinson

11 BIRTHPLACE OF FATHER (city or town) St Inigoes (State or country) Md-

12 MAIDEN NAME OF MOTHER Annie Grammer

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D C

14 Informant (Address) Records of Mt Hope Retreat Mt Hope - Balto Md

15 Filed MAY 23 1921 19 ROBERT I. LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19th 1921, to May 20 1921, that I last saw h[illegible] alive on May 20 1921, and that death occurred, on the date stated above, at 9. P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

over (duration) 0 yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile mania - (duration) 0 yrs. 4 mos. 0 ds.

18 Where was disease contracted if not at place of death? Plainfield N. J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Balto Md -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 23rd 1921
20 UNDERTAKER	ADDRESS
Henry H Jenkins Son Co	Orchard & Calhoun Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53948

CERTIFICATE OF DEATH.

92 D 53948

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 Glenwood Ave ST.; (Ward) 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Taliaferro

(Residence in Baltimore: No. 516 Glenwood Ave St.; ....yrs., 10 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, TB

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 10 (Day), 1920 (Year)

7-AGE, ...yrs. 10 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Richard Taliaferro

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Lucy Baquell

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Taliaferro

(Address) 516 Glenwood Ave

15- Filed MAY 23 1921 ROBERT E KRAUTER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 21 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from May 13 1921, to May 20 1921, that I saw her alive on May 20 1921, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John C. Baldwin M. D.

May 22 1921. (Address) 501 Fay Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery — DATE OF BURIAL, May 24 1921

20-UNDERTAKER R C Gross — ADDRESS 1405 McElderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53949

CERTIFICATE OF DEATH.

D 53949

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 13 WARD)

REGISTERED NO. C 29

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Rosenberg

(Residence in Baltimore: No. 402 Callow Ave St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1879 (Year)

7-AGE, 42 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Baltimore St

15- MAY 23 1921 ROBERT P. BRAUTIGAM

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 23 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 28 1921, to May 23 1921, that I saw h[er] alive on May 23 1921, and that death occurred, on the date stated above, at 1.10 a m.

The CAUSE OF DEATH* was as follows:

Auricular fibrillation
Gastro Intestinal Insufficiency
Uncorrected Dextrocardia

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) I. Ginsburg M. D.

May 23, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Southern Ave

DATE OF BURIAL, May 23, 1921

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Baltimore St

Please PRINT in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53950

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2710 Garrison Ave ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza B. Hayden

(a) RESIDENCE. No. 2710 Garrison Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas L Hayden

6 DATE OF BIRTH (month, day, and year) Feb 22 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Northumberland Co (State or country) Virginia

PARENTS

10 NAME OF FATHER Thaddeus Douglass

11 BIRTHPLACE OF FATHER (city or town) Northumberland (State or country) Virginia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Theo. Rittler

(Address) 2710 Garrison Ave

15 Filed MAY 23 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1921, to May 20, 1921, that I last saw h-- alive on May 20, 1921, and that death occurred, on the date stated above, at 12 45 a. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Walter A Cot, M. D.

5/22 1921 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 24 1921
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53951 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53951

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital 26 ST. WARD) 108

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna A Hausner

(a) RESIDENCE. No. 311 S. 3rd St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Apr. 18th 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Hausner

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Kane

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Joseph Hausner (Address) 1315 E. Third St.

15 Filed MAY 23 192. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/ 192

17 I HEREBY CERTIFY, That I attended deceased from 5/22/ 1921, to 5/22/ 1921, that I last saw h[illegible] alive on 5/22/ 1921, and that death occurred, on the date stated above, at 12.55A m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/22/2

Was there an autopsy? No

What test confirmed diagnosis? P.S. & Symptoms

(Signed) Frank E Hausner M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	May 25 1924
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53952

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 53952

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 631 n Duncan St., WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Friedricka Bauer

(Residence in Baltimore: No. 631 n Duncan St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Aug. 31st, 1833 (Month) (Day) (Year)

7-AGE: 87 yrs. 8 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Bauer

(Address) 631 N. Duncan

15- Filed MAY 23 192.., 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: May 20, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. K. Wesley M. D. (Coroner.)

5-20-21, (Address) 1 W. Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Balto. Cem. — DATE OF BURIAL: May 23rd, 1921

20-UNDERTAKER: Philip Herring — ADDRESS: 2046 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53953

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Kramer

(Residence in Baltimore) No. 4115 E. Lombard St.; 32 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, [illegible], 1 (Month) (Day) (Year)

7-AGE, 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fisherman
(b) General nature of industry, business, or establishment in which employed (or employer): 064

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Jacob Kramer

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dave Kramer

(Address) 4115 E Lombard st

15- Filed MAY 23 1921

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 23, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 7 1921, to May 23 1921, that I saw h[illegible] alive on May 23 1921, and that death occurred, on the date stated above, at 6.50 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Arteriosclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) L Steinberg M. D.

May 23, 1921. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 4115 E Lombard St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run

DATE OF BURIAL, May 25 1921

20-UNDERTAKER M. Levinson

ADDRESS 1127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Publid Health Hosp. #56
Fort McHenry Baltimore Md.

CITY OF BALTIMORE: (No. ..... St.: 24 Ward) 91

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Hussy

(a) RESIDENCE. No. US. Public Health Hosp. #56 Fort McHenry Md.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
-----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27 yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer: --

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar J. Rosenbush Registrar
(Address) US. P.H.S. Hosp. #56 FtMcHenry Md.

15 Filed MAY 23 1921 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 6 1921 19 ..., to May 20 1921, 19 ...,
that I last saw him alive on May 20 1921, 19 ...,
and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia broncho

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Abscess of brain
unknown (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ---

Was there an autopsy? yes

What test confirmed diagnosis? Exam. lab. report

(Signed) Thomas R. Rayne M. D.
Senior Surgeon (R)
. 19 (Address) US. P.H.S. Hosp. #56 Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL May 23 1921

20 UNDERTAKER A. Purnell & Bro — ADDRESS 1127 E Baltimore St

ROBERT J. KRAUTER
Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause of abscess unknown. No injury.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53955

CERTIFICATE OF DEATH.

1054

D 53955
REGISTERED No. C.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 546 Hanover St.: 17 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Reaber
(Residence in Baltimore: No. 546 Hanover St.: 27 yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	colored	married

6-DATE OF BIRTH, June 28, 1894
(Month) (Day) (Year)

7-AGE, 27 yrs. 10 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic 070
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Frank S. Berry
11-BIRTHPLACE OF FATHER (State or Country), Wash. D.C.
12-MAIDEN NAME OF MOTHER Elmira E. Webb
13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elmira E. Berry
(Address) 544 Hanover St.

15-
MAY 23 1921 191
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Ac. Gastro-enteritis

(Duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) contributory
(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)
May 21, 1921 (Address) 2513 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion	May 24 1921
20-UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

Spec.—6-9-19—H. P. Co.—1006 Bks.

D 53956 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53956

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1837 Lemmon ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elvan Furlong

(a) RESIDENCE. No. 1837 Lemmon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Feb 20 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) M D

PARENTS

10 NAME OF FATHER Joseph Furlong

11 BIRTHPLACE OF FATHER (city or town) (State or country) M D

12 MAIDEN NAME OF MOTHER Lucy Brashears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) M D

14 Informant (Address) Joseph Furlong 1837 Lemmon St

15 Filed MAY 23 1921 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1921, to May 22, 1921, that I last saw him alive on May 21, 1921, and that death occurred, on the date stated above at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Convulsions.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro Intestinal

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James F. Kemp M. D.

5/22 1921 (Address) 1729 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Humphries	May 23 24
20 UNDERTAKER	ADDRESS
Chenowith & Chestnut	

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53957 HEALTH DEPARTMENT—CITY OF BALTIMORE 169 D 53957

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH James Wells Rockdale

CITY OF BALTIMORE (No. #836 Powers St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W Merchant

(Residence in Baltimore—No. #836 Powers St

St.; yrs. 71 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June 26, 1915
(Month) (Day) (Year)

7-AGE, 5 yrs. 11 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS:

10-NAME OF FATHER Frank M Merchant

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Ross

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank M Merchant

(Address) 836 Powers St

15- MAY 23 192. 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental
Drowning
(Duration).....yrs. 3 mos.....ds.

CONTRIBUTORY.....
(Secondary)
(Duration).....yrs.....mos.....ds.

(Signed) John Guerriere M. D.
(Coroner.)
May 23, 1921. (Address) 3622 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, May 24 1921

20-UNDERTAKER Chenoweth Bro

ADDRESS Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53958

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. [illegible] St.; [illegible] Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. D. Rae

(a) RESIDENCE. No. 1525 Indiana St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret M. Rae

6 DATE OF BIRTH (month, day, and year) Oct. 30 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None at present

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robt Rae

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Margaret M. Rae

(Address) 1525 Williams St.

15 MAY 23 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to May 21, 1921, that I last saw him alive on May 21, 1921, and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

ONE

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. H. Wilcke M. D.

5/24, 1921 (Address) 1279 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 24 1921
20 UNDERTAKER	ADDRESS
F. X. Fanning Sons	1460 Baltimore Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition.

D 53959 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

79 D 53959

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1713 Byrd St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Deretha M. Hall.

(Residence in Baltimore: No. 1713 Byrd St.

St.; yrs., 7 mos. 5 ds. 26)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, November 25th 1913., 1 (Month) (Day) (Year)

7-AGE, 7 yrs. 5 mos. 26 ds. If LESS than 1 day, ...hrs. or....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Raymond A. Hall.

11-BIRTHPLACE OF FATHER (State or Country). Frederick Co. Md.

12-MAIDEN NAME OF MOTHER Margaret M. Wheeler.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Margaret M. Hall. (mother)..

(Address).....1713 Byrd St.....

15- FILED MAY 23 1921 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21st. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...inquiry... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) inquiry.....find that said deceased came to her..death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....Myocardial Insufficiency.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....Acute Bronchitis.....

..... (Duration).....yrs.....mos.....ds.

(Signed)..... M. D. (Coroner.)

May 22..., 1921. (Address).1017 S. Charles St..

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, May 23., 1921

20-UNDERTAKER C. D. Fanning & Son

ADDRESS 1460 Battery Ave.

GE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very
important. See instructions on back of certificate.
Every item of information should be carefully supplied. AGE sh

Spec.—6-9-19—H. P. Co.—1000 Bks.

Cron.

D 53960 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 53960

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 West Cross St. 21 Ward)

2-FULL NAME Amelia Cross

(a) RESIDENCE. No. 1118 West Cross St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21st 1888.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Penny Operator 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Peter Cross

11 BIRTHPLACE OF FATHER (city or town)
(State or country) France

12 MAIDEN NAME OF MOTHER Catherine Mungold

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant William Mungold
(Address) 1118 W. Cross St

15 Filed MAY 23 1921 [illegible] Registrar

[illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from April 2nd, 1921, to May 22nd, 1921, that I last saw h[illegible] alive on May 21st, 1921, and that death occurred, on the date stated above, at 1.50 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
General T.B.

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm S. Perkins, M. D.

, 19 (Address) W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 24. 1921
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Frederick Ave.

CAUSE OF DEATH IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53961

CERTIFICATE OF DEATH.

X 34 D 53961

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen B Brennan

(a) RESIDENCE. No. 265 N. Sixth St. Newark ST. N.J. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH must be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas. L. Brennan

6 DATE OF BIRTH (month, day, and year) March 21 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of wnrk: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Owego N.Y.

PARENTS

10 NAME OF FATHER Andrew Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Shontz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Johns Hopkins Hospital's Bureau

15 Filed MAY 23 1921 [illegible]

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan. 26 —, 1921, to May 22 —, 1921, that I last saw h— alive on May 22 —, 1921, and that death occurred, on the date stated above, at 2 35 p m.

The CAUSE OF DEATH* was as follows:

Bilateral Tuberculosis of Kidneys.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tbc. Miliary, Terminal

(duration) — yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? do not know

Did an operation precede death? yes Date of Aug. 4. 1918

Was there an autopsy? no —

What test confirmed diagnosis? Microscopical & clinical

(Signed) L. P. Wharton —, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Owego N.Y.	May 23 1921

20 UNDERTAKER	ADDRESS
John D. Mitchell	1201 N. Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53962

CERTIFICATE OF DEATH.

97

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1119 N Montford ST.: 8 WARD)

2-FULL NAME Lemure Walker

(a) RESIDENCE. No. 1119 N. Montford ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of no

6 DATE OF BIRTH (month, day, and year) June 27. 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Anthony Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Mary Fuller
(Address) 1119 N. Montford,

15 Filed MAY 23 1921

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 21 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to May 21, 1921, that I last saw h[illegible] alive on May 20, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal Intoxication

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos Fa Stevens, M. D.

5/21, 1921 (Address) 2866 Leaford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 24 1921
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son, Funeral Directors & Embalmers.	811 W Lo[illegible] St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53963 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

184 D 53963
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Johns Hopkins Hosp. ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian E. Hill

(Residence in Baltimore: No. 906 S. First St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White.	Married

6-DATE OF BIRTH, March (Month) 3 (Day), 1899 (Year)

7-AGE, 22 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, William Hilker

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Annie Jones

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathew Hill

(Address) 906 S. First St.

15- [illegible]

Filed MAY 23 1921 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 20 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abortion - septic

Induced (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Ernest Lowden (Coroner) M. D.

5-21, 1921. (Address) 11 E. Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel Cem.	May 24, 1921
20-UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53964

D 53964

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 1 Bay ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Hechtner

(a) RESIDENCE. No. 702 1 Bay ST., ... WARD. 13

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stripper Cork 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co

PARENTS

10 NAME OF FATHER: Frederick B Hechtner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Sears

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Elizabeth Hechtner

(Address) 702 Bay

15 Filed MAY 23 1921 ... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17

I HEREBY CERTIFY, That I attended deceased from Dec 1st 1920, to May 22 1921, that I last saw him alive on May 22 1921, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

5/23 1921 (Address) 846 W 36 or 80

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL: May 25 1921

20 UNDERTAKER: Mulhain Corse

ADDRESS: 5042 N Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of ... certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53965

CERTIFICATE OF DEATH.

45 D 53965

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospl. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Mead.

(a) RESIDENCE. NO. 419 W. Mulberry ST. St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ Mrs Anna Mead.

6 DATE OF BIRTH (month, day, and year) April 5 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Mrs Annie B. Mead
(Address) 419 W. Mulberry St

15 Filed MAY 23 1921 ROBERT J. KRAUTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-16-, 1921, to 5-21-, 1921, that I last saw him alive on 5-21-21, 19, and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Soft Parts with metastasis to Mediastinum & Lungs.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure-pul- monary Oedema.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin Record

(Signed) W. M. Craig, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 24 1921
20 UNDERTAKER	ADDRESS
H. Sander Sons	710 Park

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53966

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53966

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 509 S. Milton Ave ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harlow B. Elliott

(a) RESIDENCE. No. 509 S. Milton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna C. Elliott

6 DATE OF BIRTH (month, day, and year) April 12 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 00D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Ferdinand Klotz

(Address) McDonogh Balto Co.

15 Filed MAY 23 1921 ROBERT A. BRAUTE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1921, to May 21, 1921, that I last saw ~~him~~ alive on May 21, 1921, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Dis Heart

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. H. Neer, M. D.

5/24/21 (Address) 400 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	May 24 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Pleasant St

CAUSE OF DEATH in plain terms, so that it should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53967

CERTIFICATE OF DEATH.

64 D 53967

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia McLewee

(a) RESIDENCE. No. 109 S. Bouldin St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address): New City Hospital.

15 Filed MAY 23 1921 ROBERT J. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1921. to May 21. 1921.

that I last saw her alive on May 20. 1921.

and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis, hypertension. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clo especial test.

(Signed) B Herman. M. D.

5/21/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	May 23 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1310 Fremont

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53968

D 53968

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Carlton Terrace St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgiana Webster

(Residence in Baltimore: No. 1618 Carlton Terrace St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widd

6-DATE OF BIRTH, ... (Month) ..... (Day) 1847 (Year)

7-AGE, 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Gus Brookfield

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rezah Cullen

(Address) 1618 Carlton Terrace

15- Filed MAY 23 1921 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 21 (Day), 1921 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Apr 30 1921, to May 20 1921, that I saw h— alive on May 20 1921, and that death occurred, on the date stated above, at 8h. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Contributory to

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. Garland Cotwell M. D.

May 23 1921. (Address) 1534 29 W Lan

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cmty

DATE OF BURIAL, May 25 1921

20-UNDERTAKER George H. Holland

ADDRESS 1631 Lewis Gilfoil

Burial Permit Given

Registrar.

May be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53969
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 Carey ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Grate

(a) RESIDENCE. NO. 1528 Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	c	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Arthur

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Maggie Curtis
(Address) 1528 N. Carey St

15 Filed MAY 23 1921 ROBERT F. LAUTER Registrar
Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19 1921

17 I HEREBY CERTIFY, That I attended deceased from 3/15 1921, to 5/19 1921,
that I last saw h 4 alive on 5/19 1921,
and that death occurred, on the date stated above, at 9 35 m.

The CAUSE OF DEATH* was as follows:

Chr. Gastr. enteritis +

Chr. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burt Rhutts M. D.

, 19 (Address) 1/4 D. H. G

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	May 23 1921
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53970

CERTIFICATE OF DEATH.

15 - 120 D 53970

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3400 Powhatan Ave. ST.: 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Taylor Gill

(a) RESIDENCE. No. 3400 Powhatan Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Gill

6 DATE OF BIRTH (month, day, and year) Dec. 3" 1855

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired- Foreman 073

(b) General nature of industry, business, or establishment in which employed (or employer) B and O R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md.

PARENTS

10 NAME OF FATHER Edward Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia McNamara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Mary E. Gill (Address) 3400 Powhatan Ave.

15 MAY 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21" 19 21

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1920, to May 20, 1921, that I last saw h[illegible] alive on May 20, 1921, and that death occurred, on the date stated above, at 10.35A m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Hepatitis Interstitial

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood & Urine

(Signed) H. K. Warner M. D.

May 23, 1921 (Address) 700 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL May 24 1921

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53971 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53971

CERTIFICATE OF DEATH

1-PLACE OF DEATH US. Public Health Hosp. #56 Fort McHenry Baltimore Md. REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Md. ST.: 24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lyle Tilton

(a) RESIDENCE. No. US. Public Health Hosp. #56 ST., WARD. Fort McHenry Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) --

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32 yrs	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber 004

(b) General nature of Industry, business, or establishment in which employed (or employer): --

(c) Name of employer: --

9 BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Josephine Tilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant Edgar T. Rosenbach Registrar
(Address) US. Public Health Hosp. #56 Md.

15 Filed MAY 23 1921 19 Registrar

Burial Permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17 I HEREBY CERTIFY, That I attended deceased from May 14 1921, to May 21 1921, that I last saw him alive on May 21 1921, and that death occurred, on the date stated above, at 5'10 a. m.

The CAUSE OF DEATH* was as follows:

Alcohol posioning acute

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis acute (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? no

What test confirmed diagnosis? Exam. Clinic report

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)

. 19 (Address) US. PHS Hosp. #56 FtMcHenry Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 24 1921

20 UNDERTAKER Joseph L. B. Cook ADDRESS 1003 N Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Alcoholism.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53972

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 53972

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2416 W Lanvale ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Wright

(a) RESIDENCE. No. 2416 W Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. Wright

6 DATE OF BIRTH (month, day, and year) July 12 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John McMaines

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Jane Mahon

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Frederick L. Roden
(Address) 2416 W Lanvale St

15 Filed MAY 23 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to May 22, 1921, that I last saw her alive on May 22, 1921, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) chronic interstitial nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. W. Wrager, M. D.

May 22 1921 (Address) 1014 S. Belnord Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 24 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53973 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37 D 53973

REGISTERED NO.

1-PLACE OF DEATH Boy View Hospital

CITY OF BALTIMORE: No. ... ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George King

(a) RESIDENCE. NO. ... Parkwood ST., ... WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do.

12 MAIDEN NAME OF MOTHER: Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Boy View Hospital Catonsville, Md

15 MAY 23 1921 ... Registrar

BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20, 19 21

17 I HEREBY CERTIFY, That I attended deceased from May 17, 19 21, to May 21, 19 21, that I last saw him alive on May 19, 19 21, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the insane)

... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia.

... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Surgical

(Signed) H. G. Cosgrove M. D.

5/24/1921 (Address) Boy View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetary	5/23/21.

20 UNDERTAKER: E & B Hale ADDRESS: 115 E Mul

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 53974

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2833 Remington ave. WARD) 17

2-FULL NAME William H. Stewart

(a) RESIDENCE. No. 2833 Remington ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Laura Stewart

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 047

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Middlesex co
(State or country) Virginia

PARENTS

10 NAME OF FATHER Thos. Stewart

11 BIRTHPLACE OF FATHER (city or town) Taylsons
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mollie Byrd

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Laura Stewart
(Address) 2833 Remington ave

15 MAY 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 17th, 1921, to May 20, 1921, that I last saw h[illegible] alive on May 20, 1921, and that death occurred, on the date stated above, at 3-5 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) x yrs. x mos. ? ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) x yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Ged. F. Wall, M. D.

, 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL May 23 19 21

20 UNDERTAKER Edward Handley ADDRESS 57 S Bridle

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53975

CERTIFICATE OF DEATH.

D 53975

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Hoffman ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Lestermann

(Residence in Baltimore: No. 611 Hoffman St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 18?1 (Year)

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), St. Marys Co. Md

PARENTS.

10-NAME OF FATHER, Wm Holley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Summerville

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph B. Cole

(Address) 611 W. Hoffman St.

15-

Filed MAY 23 1921, 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 14 1921, to May 21 1921, that I saw her alive on May 21 1921, and that death occurred, on the date stated above, at ' m.

The CAUSE OF DEATH* was as follows:

Uterus Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senescence no fear

..... (Duration) ..... yrs. ..... mos. 21 ds.

(Signed) ..... M. D.

5/22, 1921 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Leatherdale Cem. DATE OF BURIAL, May 25, 1921

20-UNDERTAKER Samuel Hendley ADDRESS Biddle St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks Gangrene not due to injury. No terminal hemorrhage. Physician state, name is Mary Cole.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

John Louis Boone)

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53976

D 53976

CERTIFICATE OF DEATH.

X 79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Louis Boone

(a) RESIDENCE. NO. 1734 N. Montford Ave ST., WARD. West Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Catherine E. Boone

6 DATE OF BIRTH (month, day, and year) Mar 12, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer (Ret'd)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER Louis Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Sarah Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Catherine E. Boone

(Address) Baker Wagon-Grove St.

15 Filed MAY 23 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1921

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1921, to May 20, 1921, that I last saw h[illegible] alive on May 20, 1921, and that death occurred, on the date stated above, at 11.00 A. m.

The CAUSE OF DEATH* was as follows:

Uremia Sclerosis

Mitral Regurgitation

(duration) ?, yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) C. Wilbur Stewart, M. D.

5/20, 1921 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: May 23 1921

20 UNDERTAKER: Harry H Witzke — ADDRESS: 1531 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. — 6-9-19 — H. P. Co. — 1000 Bks.

D 53977 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53977

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH Hamilton, Baltimore

CITY OF BALTIMORE: (No. Beechwood & Augusta Aves. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Hilbinger

(a) RESIDENCE. NO. Beechwood & Augusta Aves ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret Hilbinger

6 DATE OF BIRTH (month, day and year) Feby 14 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 00
(b) General nature of Industry, business, or establishment in which employed (or employer) same
(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Sebastian Hilbinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Hilbinger
(Address) Hamilton Balto Md

15 FILED MAY 23 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1921, to May 21, 1921, that I last saw him alive on May 20, 1921, and that death occurred, on the date stated above, at 6 25 a. m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia
(Cerebral Hemorrhage)
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Right Hemiplegia (Cerebral Hemorrhage)
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Brown, M. D.

5/27, 1921 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL 5/24/21

20 UNDERTAKER Geo. J. Ruth — ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53978

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53978

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2839 W. Fourth St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F. A. Richter

(Residence in Baltimore: No. 2839 W Fourth St.; 60 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, November 11, 1851.
(Month) (Day) (Year)

7-AGE, 69 yrs. 6 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 08

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Charles Richter

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank L. Black

(Address) 2839 W. Fourth Av

15-

Filed MAY 23 1921 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 22nd, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 19th, 1914, to May 22nd, 1921, that I saw h.im alive on May 22nd, 1921, and that death occurred, on the date stated above, at 12.15 noon.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
with Uremic Seizure.

(Duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. 5 ds.

(Signed) Edgar S. Pirkins M. D.

May 22nd, 1921. (Address) 1 W Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Woodlawn	May 24, 1921.

20-UNDERTAKER	ADDRESS
Geo W Little	2700 Edmondson Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53979

D 53979

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Young.

(a) RESIDENCE. No. #331 Dover St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE — Years: 50 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant.....
(Address)

15 MAY 23 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1921

17

I HEREBY CERTIFY, That I attended deceased from May 16, 1921 to May 17, 1921, that I last saw him alive on May 17, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency & Stenosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema Lungs.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Geyer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: MAY 23 1921

20 UNDERTAKER

ADDRESS

Commissioner Health

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53980 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53980

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Linden Avenue ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Howley

(a) RESIDENCE. No. 1506 Linden Avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	70	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Howley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hanrahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant H. W. Mears & Son's Records
(Address) 805 N. Calvert Street

15 Filed MAY 23 1921 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to May 20, 1921, that I last saw her alive on May 20, 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Gunshot Brain

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Coroner

(Signed) Charles O'Donovan, M. D.

May 21, 1921 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 5/24/21

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53981 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53981

CERTIFICATE OF DEATH.

89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1135 N. Monroe ST. 16 WARD)

2-FULL NAME James M. Walsh

(a) RESIDENCE. NO. 1135 N. Monroe ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Baker

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James H Walsh

11 BIRTHPLACE OF FATHER (city or town) Hampstead (State or country) Maryland

12 MAIDEN NAME OF MOTHER Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant James H Walsh
(Address)

15 Filed MAY 23 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1921, to May 22, 1921, that I last saw him alive on May 22, 1921, and that death occurred, on the date stated above, at 8 45 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Dilatation Stomach

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? — Date of —

Was there an autopsy? — no

What test confirmed diagnosis? no

(Signed) W D Wells, M. D.

. 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Joseph Cemetery Govans Md	May 24 1921
20 UNDERTAKER	ADDRESS
Martin Fraley & Sons	1827 N Fulton Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 53982

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2908 Wallbrook Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine R Shipley

(a) RESIDENCE. No. 2908 Wallbrook Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER John Bligyard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co.

12 MAIDEN NAME OF MOTHER Nancy Ogg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Mrs Barthoe (Address) 2908 Wallbrook Ave

15 Filed MAY 23 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... should state TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921.

17 I HEREBY CERTIFY, That I attended deceased from August, 1920, to May 22, 1921, that I last saw h... alive on May 22, 1921, and that death occurred, on the date stated above, at 6-45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma involving lower third of esophagus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W J Faus, M. D.

May 23, 1924 (Address) 720 N. Monk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stamber Carroll Co Md.	May 25th
20 UNDERTAKER	ADDRESS
M E Tossom	840 W 31st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53983 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53983

CERTIFICATE OF DEATH. X 157

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Beale

(a) RESIDENCE. NO. Flemington Pa ST., ... WARD. Dixie

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER J. H. Beale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Austin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAY 23 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 - 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 1921, to May 22, 1921, that I last saw h... alive on May 22 - 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Infantile Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 24 hrs.

CONTRIBUTORY (Secondary) Birth Injury

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

5-23-1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lochhaven, Pa.	5-23-1921
20 UNDERTAKER J. G. Moran	ADDRESS 900 E. Baltimore

FAILURE TO FILL OUT THIS CERTIFICATE WITH UNDERSTANDING IN EVERY ITEM OF INFORMATION IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Child born in Penna.
Sent to Hopkins with
phy. and nurse. Died
at Hopkins Hospt.

D 53984

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53984

CERTIFICATE OF DEATH.

64

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Apart 10 D. Marlborough St. Ward 14)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis M. Getz

(Residence in Baltimore: No. Apartment 10 D. Marlborough Apart. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, ... Feb. 4 ....., 1856
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
65 yrs. 3 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stock Broker
(b) General nature of industry, business, or establishment in which employed (or employer)..... O.B.

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Charles Getz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Rose Steigerwald

13-BIRTHPLACE OF MOTHER (State or Country), ~~Germany~~ Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. M. Getz

(Address) 10 D. Marlborough Apart

15- Robert P. Harrison,

Filed....., 191.....

MAY 23 1921 Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May ..... 22 ....., 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ~~inquest~~
(Inquest, autopsy or inquiry.)
Coroner find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Duration one week
(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) no history
(Duration)....yrs....mos....ds.

(Signed) J. R. Hennessy M. D.
(Coroner.)
May 22 1921. (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Hebrew	May 24 1921.
20-UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Madison

IMPORTANT. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53985 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53985

CERTIFICATE OF DEATH.

1485 X 38 REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Jackson

(a) RESIDENCE. No. Cutland Md. Howard Sts. WARD. Cutleland Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Perry Jackson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Wesley Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Stacy Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Johns Hopkins Hospital's Records

15 Filed MAY 23 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17 1921 to May 22 1921, that I last saw her alive on May 22 1921, and that death occurred, on the date stated above, at 6 40 A. m.

The CAUSE OF DEATH* was as follows:

Generale Peritonitis —

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Salpingitis —

(duration) One yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? yes Date of 5/20/21

Was there an autopsy? yes —

What test confirmed diagnosis? autopsy

(Signed) L R Wheaton, M. D.

5 23, 1921 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Freetown cem Howard Co	May 25 1921
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AY 23 1921

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonococcus infection.

(Jordon)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53986 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53986

109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Gordon

(a) RESIDENCE. No. 1312 Gorgas Court WARD. Md. General Hospital

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred more than 20 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Owen Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Cain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Harman

(Address). Catonsville Md.

15 Filed Y.23 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to May 22, 1921, that I last saw her alive on May 22, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Strangulated r.t. inguinal Hernia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation 7463

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? Yes Date of May 20, 21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M. P. Pope Lumpkin M. D.

, 19 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 25 '21

20 UNDERTAKER	ADDRESS
Harry H. Witzke	1311 Wilkens Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53987. HEALTH DEPARTMENT—CITY OF BALTIMORE. 154 D 53987.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 42nd St.; 27 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas H. Kidd

(Residence in Baltimore: No. 500 42nd St. St.: 87 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. MALE | 4-COLOR OR RACE, WHITE | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Sept 17, 1833 (Month) (Day) (Year)

7-AGE 87 yrs. 8 mos. ds. | If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Chas H. Kidd. Sr

11-BIRTHPLACE OF FATHER (State or Country), Cecil County Md

12-MAIDEN NAME OF MOTHER Ruth Griffith

13-BIRTHPLACE OF MOTHER (State or Country), Cecil Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Howard Kidd

(Address) 2727 Maryland Ave

15-

Filed ..... 191.....

Robert P. Harrison,

Burial Permit Clerk, Registrar.

MAY 23 [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 22, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1921, to May 22 1921, that I saw him alive on May 22 1921, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

old age: General decline

No Disease

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) E. M. Duncan M. D.

May 23, 1921. (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, ST. VINCENT'S | DATE OF BURIAL, May 24, 1921.

20-UNDERTAKER ROBERT BROOKSTON | ADDRESS 175 CALHOUN St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 53988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53988

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 N. Vincent ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Stratter

(Residence in Baltimore: No. 11 N. Vincent St. St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, (Month) Unknown (Day), 1851 (Year)

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work.
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Mercer

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Celie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Stratter

(Address) 11 N. Vincent st

15-

Robert P. Harrison,

Filed MAY 23 1921, 191

Burial Permit Clerk, Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15 1921, to May 21 1921, that I saw h[illegible] alive on May 21 1921, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Incompetency

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Articular Rheumatism

(Duration) yrs. 2 mos. ds.

(Signed) J. M. Hupp M. D.

5/23, 1921 (Address) 513 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Md Auburn Cem. DATE OF BURIAL, May 24th 1921

20-UNDERTAKER A. Jones ADDRESS 207 S. Stricker st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53989 HEALTH DEPARTMENT—CITY OF BALTIMORE D 53989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Reisterstown Rd & Morris ST.: 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert L Smith

(a) RESIDENCE. No. Reisterstown Rd & Morris ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 6 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 9 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter X. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mabel Lines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mich

14 Informant Mabel Smith

(Address) Reisterstown Rd

15 Filed MAY 23 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 22, 1921, that I last saw him alive on May 22, 1921, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis and Pericarditis.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pleuro Pneumonia, Possible Typhoid Fever

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Positive Widal

(Signed) C. B. Enson, M. D.

5-23 1921 (Address) 5016 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 24 21
20 UNDERTAKER	ADDRESS
Wm Tuckwell Sons	North Ave

This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53990
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 53990
REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1021 Mornis ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emmie Wayne

(Residence in Baltimore: No. 1021 Morris St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-WHETHER SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown, 1861
(Month) (Day) (Year)

7-AGE, 60, 7 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) -

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie M. Wayne

(Address) 1021 E. Morris St.

15- MAY 24 1921 ROBERT A. KRAUTER
Filed....., 191..... CITY REGISTRAR (Clerk)
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21st, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1920 to May 21st 1921, that I saw h[illegible] alive on May 20th 1921, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

D. Carcinoma Uterus

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Lee Ellis M. D.

May 23, 1921 (Address) 724 Mosher St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, May 24, 1921

20-UNDERTAKER Samuel Hensley ADDRESS 575 Mad. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53991

CERTIFICATE OF DEATH.

D 53991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Molly Crawford

(a) RESIDENCE. No. 1528 Madison Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	X	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook — 021

(b) General nature of industry, business, or establishment in which employed (or employer) Private Family

(c) Name of employer Mrs Taylor - 1528 Madison ave.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Charles Taylor

(Address) 1528 Madison Ave

15 Filed MAY 24 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1921

17

I HEREBY CERTIFY, That I attended deceased from May 13th 1921, to May 21st 1921, that I last saw h[illegible] alive on May 21st 21, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Harry F. Brown M. D.

1924 (Address) 15 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 24 1921
20 UNDERTAKER	ADDRESS 578
Samuel T Newsby	Mt Auburn Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53992

CERTIFICATE OF DEATH.

120

D 53992

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 Falls Rd ST.: 13 WARD)

2-FULL NAME Rev Thos Jones

(a) RESIDENCE. No. 230 Falls Rd ST., WARD.....
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Jones

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Home work

(c) Name of employer Self Druid Hill Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Sydney Henry

(Address) 228 Falls Rd.

15 Filed MAY 24 1921 ERT A KRAUTER Registrar

Burial Permit Oler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17

I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 21, 1921, that I last saw him alive on May 21 1921, and that death occurred, on the date stated above, at 2.15 p m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Nephritis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Short, M. D.

May 21 1921 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL May 24-21

20 UNDERTAKER Osmond Hensley ADDRESS 1218 Bolton

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably old chronic condition of kidney. No other abnormal condition.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 53993 HEALTH DEPARTMENT—CITY OF BALTIMORE VD 53993

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N. Hoffman ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Flushing

(a) RESIDENCE. No. 509 N. Hoffman ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook & Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer ~~Mrs. C. J. Taylor~~

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Edward Jennings

(Address) 1523 Eastlake Ave.

15 Filed MAY 24 1921 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/1921

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to May 22, 1921, that I last saw h... alive on May 21, 1921, and that death occurred, on the date stated above, at 9:50 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins M. D.

. 19 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	May 24 21
20 UNDERTAKER	ADDRESS 1375 Eddle
Samuel Handley	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53994

CERTIFICATE OF DEATH.

105

D 53994

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1007 Parish ST.: 14 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Deuk

(Residence in Baltimore: No. 505 Wilson St. St.: yrs. 39 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	single

6-DATE OF BIRTH, Oct. 5, 1881
(Month) (Day) (Year)

7-AGE, 33 yrs. 7 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Josef J. Deuk

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Catlyn Gray

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Regina Deuk Martin

(Address) 505 Wilson St

15-

Filed MAY 24 1921 191.... Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH May 21, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the date stated above.

The CAUSE OF DEATH* was as follows:

Ac. Gastro enteritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

May 23 1921 (Address) 2802 Edgewood Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	May 24, 1921
20-UNDERTAKER	ADDRESS
Joseph A Farrell	2314 Division

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53995

CERTIFICATE OF DEATH.

28 D 53995

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4 ST.; WARD)

2-FULL NAME Ella Molloy

(a) RESIDENCE. No. 233 Myrtle Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hays Molloy

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ..

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hospital (Address) Balto. Md

15 Filed MAY 24 1921 19 ROBERT J. BRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 20 1921, to May 21 1921, that I last saw h.. alive on May 20 1921, and that death occurred, on the date stated above, at 6.00 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic Psychosis

.... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) H. W. Dennett M. D.

5/21/1921 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
at Auburn	May 24 1921
20 UNDERTAKER Joseph A Farrell	ADDRESS 2319 Division

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53996

CERTIFICATE OF DEATH.

28

D 53996

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 St.: Municipal Tuberculosis Hospital Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Newton

(a) RESIDENCE. No. Green & Baltimore st. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Fredricka Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records
(Address) M.T.H.

15 Filed MAY 24 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1921

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to May 21, 1921,

that I last saw him alive on May 21, 1921,

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) L. Pilgrey, M. D.

5-21-21 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	5/24/21

20 UNDERTAKER Chas L. Evans Son & Moore ADDRESS Regal Co

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 53997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 x 24 D 53997

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital St.: 4 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Thomas

(a) RESIDENCE. No. Rock Hall Md St., Ward. Rock Hall Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Eichhart

6 DATE OF BIRTH (month, day, and year) July-22-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54 years	10	1	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Fisherman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rock Hall Sent Co Md

PARENTS

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Lucena Thomas

11 BIRTHPLACE OF FATHER (city or town) Md (State or country) France

12 MAIDEN NAME OF MOTHER Catherine Halbert

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania (State or country)

14 Informant Mr Elizabeth Thomas (Address) Rock Hall Md

15 Filed MAY 24 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/23 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-22, 1921, to 5/23, 1921, that I last saw h[illegible] alive on 5/23, 1921, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Tetanus

(supposed by running nail in bottom of foot May 14th)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Phrenic Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Zeb Hooper, M. D.

(Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall Md.	May 24 1921

20 UNDERTAKER N. E. Hughes ADDRESS 412 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53998

D 53998

CERTIFICATE OF DEATH.

REGISTERED NO. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 4 Schaffer Ave, Hamilton ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Thomas Edwards

(a) RESIDENCE. NO. 4 Schaffer Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of husband of Ella May Edwards

6 DATE OF BIRTH (month, day, and year) Aug 18.1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Commissionn

(b) General nature of industry, business, or establishment in which employed (or employer): Product

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Balto Co

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John Edwards

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Wales

12 MAIDEN NAME OF MOTHER: Elizabeth Biddison

13 BIRTHPLACE OF MOTHER (city or town): Balto.Co.

(State or country): Maryland

14 Informant: Ella May Edwards

(Address): 4 Schaffer Ave

15 MAY 24 1921 [illegible]

Burial [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22.1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1917, to May 22 1921, that I last saw him alive on May 21, 1921, and that death occurred, on the date stated above, at 6:20 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Geo. T. Edwards M. D.

May 23 1921 (Address) 27 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 24 1921
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

...—8-24-14—M. & T.—2000 Bks.

D 53999 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D 53999

1-PLACE OF DEATH

Y OF BALTIMORE: (No. 505 Mc Mechen ST.; 14 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zelma Bowyer

idence in Baltimore: No. 505 Mc Mechen St.; ...yrs., ...mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
De	Col	Single

TE OF BIRTH, 5 (Month) 19 (Day), 1921 (Year)

...yrs. ...mos. 3 ds. If LESS than 1 day, ...hrs. or ...min.?

CUPATION: (a) Trade, profession, or particular kind of work: None (b) General nature of industry, business, or establishment in which employed (or employer): 000

THPLACE, (State or Country): Maryland

10-NAME OF FATHER: Zander Bowyer

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Leila Rich

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

nformant): Leila Rich

(Address): 1334 E. H Ave

MAY 24 1921 ROBERT A. LAMOTTE CLERK

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1921, to May 22 1921, that I saw her alive on May 22 1921, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Prematyre Birth, Cause

Premature Birth, Umbon

Mem. of Uterine gestation

(Duration) ...yrs. 7 mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) R. Garland Smith M. D.

May 23, 1921. (Address) 1534 E. H Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, W. Berkley Cem. DATE OF BURIAL, MAY 24 1921

20-UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54000

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 14 54

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Ebb

(a) RESIDENCE. No. 565 Mosher St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Ebb

11 BIRTHPLACE OF FATHER (city or town) St. Mary's Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Gass

13 BIRTHPLACE OF MOTHER (city or town) Carrol Co. (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed MAY 24 1921 ROBERT A. LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921 to May 21, 1921, that I last saw h... alive on May 21, 1921, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood examinations.

(Signed) V. H. Herman. M. D.

5/23/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Star Western DATE OF BURIAL MAY 25 1921

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54001

CERTIFICATE OF DEATH.

37 D 54001

1-PLACE OF DEATH US. Public Health Hosp. #56 Fort McHenry Baltimore Md.

CITY OF BALTIMORE: (No. ..... ST.: 34 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Segel

(a) RESIDENCE. No. US. Public Health Hosp. #56 ST.. WARD Fort McHenry Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
21	yrs.	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

086

9 BIRTHPLACE (city or town) (State or country) ~~unknown~~ Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Isenbark Registrar

(Address) US. Public Health Hosp. #56

15 Filed MAY 24 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17 I HEREBY CERTIFY, That I attended deceased from March 16 1921, to May 21 1921, 19 , that I last saw h[illegible] alive on May 21 1921, 19 , and that death occurred, on the date stated above, at 3'10 a. m.

The CAUSE OF DEATH* was as follows:

Syphilis general

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia broncho

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of --

Was there an autopsy? yes

What test confirmed diagnosis? Exam.

(Signed) Thomas R. Payne M. D.
Senior Surgeon (R)

, 19 (Address) US. P.H.S. Hosp. #56 Ft.McH. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Ft. McHenry MAY 24 1921

20 UNDERTAKER — ADDRESS

JAMES H. DENNIS 1303 PRESTMAN ST.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54002

CERTIFICATE OF DEATH.

D 54002

97

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Baker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Francis Hawkins

(a) RESIDENCE. NO. 604 Baker ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Estell Hawkins

6 DATE OF BIRTH (month, day, and year) Dec 22, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. Dr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Philadelphia Restaurant

9 BIRTHPLACE (city or town) (State or country) Charles Co. Md.

PARENTS

10 NAME OF FATHER George Raymond Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Mary Jane Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co. Md

14 Informant Mary A. Hawkins (Address) 604 Baker St

15 Filed MAY 24 1921 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1921, to May 22, 1921, that I last saw h... alive on May 22, 1921, and that death occurred, on the date stated above, at 2.25 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Philadelphia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Wm. H. Wright M. D.

(Address) 1309 Prestman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem.	MAY 24 1921
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 54003 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54003

CERTIFICATE OF DEATH.

93

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Mount Hope Retreat ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Lingan

(a) RESIDENCE. No. 2719 Parkwood Ave ST., Balto md WARD. Lived in Balto. one yr.
(Usual place of abode) at Hope
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~Jan~~ 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hartford Co
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm E. Lingan

11 BIRTHPLACE OF FATHER (city or town) Hartford Co
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary E. Lynch

13 BIRTHPLACE OF MOTHER (city or town) Hartford Co
(State or country) Maryland

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md.

MAY 24 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from April 13th, 1921, to May 23rd, 1921, that I last saw h[illegible] alive on May 22nd, 1921, and that death occurred, on the date stated above, at 7.40 ~~P~~ A. m.

The CAUSE OF DEATH* was as follows:

Gen. Neuritis - (with Sudden Termination by Cardiac Syncope)

abt (duration) 0 yrs. 4 mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Mania - abt (duration) 0 yrs. 4 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 23rd 1921 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 26 1921
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state it very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 54004 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Baker ST.; 15 WARD) REGISTERED NO. C 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilbur Chalk

(Residence in Baltimore: No. 2211 Baker St St.; 11 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Aug. (Month) 6 (Day), 1912 (Year)

7-AGE.	If LESS than 1 day,
8 yrs. 9 mos. 17 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Wilbur M. Chalk

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Maud Percy

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilbur M. Chalk

(Address) 2211 Baker St.

15- [illegible] A KRAUTH

FILED MAY 24 1921 191.... Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 23 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1921, to May 23 1921, that I saw h[illegible] alive on May 23 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Coe)

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) About 15 Minutes yrs. mos. ds.

(Signed) O. N. Duvall M. D.

May 23, 1921. (Address) 1817 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
London Park	May 24th, 1921.
20-UNDERTAKER	ADDRESS
Wilbur W. Shriver	1018 Edmondson Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Mieczslaus Gronski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54005

CERTIFICATE OF DEATH.

8-09

D 54005

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 S Durham ST.: 7th WARD)

2-FULL NAME Mieczslaus Gronski

(a) RESIDENCE. NO. 322 S Durham ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaus Gronski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Clementyna Mieviadomska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaus Gronski (Address) 322 S Durham

15 Filed MAY 24 1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to May 22, 1921, that I last saw h[illegible] alive on May 22, 1921, and that death occurred, on the date stated above, at 1040 Pm.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

5/24/21, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 24 1921

20 UNDERTAKER John M. Feher ADDRESS 1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia: Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Phy. only attended 2 days
Gave history of having had
whooping cough about
1 month and had ago.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54006

CERTIFICATE OF DEATH.

175 D 54006

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hos. St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos. Metz (Miezis)

(Residence in Baltimore: No. 217 S. Hanover St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... March ....., 1866
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
55 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Smemeenas

(Address) 217 S. Hanover St

15- MAY 24 1921 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident

Bruises (Multiple)

(Duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Gen. Septicemia

(Duration) 5 yrs. 1 mos. ds.

(Signed) G. Clinton Wade M. D.
(Coroner.)

May 24, 1912. (Address) 143 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	May 24 1912

20-UNDERTAKER	ADDRESS
John Grebliauskas	425 S. Paca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54007

CERTIFICATE OF DEATH.

D 54007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 Wilcox ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Kennedy

(a) RESIDENCE. NO. 1321 about Wilcox ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of the late Bridget Kennedy

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary 186

(b) General nature of industry, business, or establishment in which employed (or employer) Fireman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Thomas M. Kennedy

(Address) 1321 Hanover St

15 Filed MAY 24 1921 19 COLLER & KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 1921

17

I HEREBY CERTIFY, That I attended deceased from May 3 1921, to May 23 1921, that I last saw h. m. alive on May 22 1921, and that death occurred, on the date stated above, at 6 45 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

Clinical Diagnosis, No Aut.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Gradual Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Weis M. D.

19 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 27 1921
20 UNDERTAKER	ADDRESS
Henry Hosch & Son	1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54008

CERTIFICATE OF DEATH.

104 D 54008

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N. Bradford ST.; 7 WARD)

2-FULL NAME William C Lang.

(a) RESIDENCE. No. 509 N. Bradford ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) Feb 16 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John G. Lang

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Jennie Jemison

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant John G. Lang
(Address) 509 N. Bradford St.

15 Filed MAY 24 1921 ...[illegible]... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-23 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-[illegible], 1921, to 5-23, 1921, that I last saw h... alive on 5-23, 1921 and that death occurred, on the date stated above, at 11:30 A.m.

The CAUSE OF DEATH* was as follows:

Ulceration Intestines

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) T. F. Ritzinger, M. D.

5-24 1921 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	May 25 1921
20 UNDERTAKER	ADDRESS
Thos C. Miller	2334 Jefferson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54009

CERTIFICATE OF DEATH.

4 55-001

D 54009

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 W Lexington ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie L Doberer

(a) RESIDENCE. No. 504 W Lexington ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15-77

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo Doberer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Louise List

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Annie Doberer
(Address) 504 W Lexington

15 Filed MAY 24 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to May 22, 1921, that I last saw h[illegible] alive on May 22, 1921, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) - yrs. 1 mos. x ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Geo Talbott, M. D.

5/23, 1921 (Address) 1353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Parkbem	May 24 1921
20 UNDERTAKER	ADDRESS
W M Rountree	By 2268 W Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Volunteers of America 21 91 REGISTERED NO.

CITY OF BALTIMORE: (No. 418 W Lexington ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Daly

(a) RESIDENCE. No. 932 S. Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	maried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: anna Daly

6 DATE OF BIRTH (month, day, and year): may 2 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glassblower 086

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Wm. W. Swindell

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa

PARENTS

10 NAME OF FATHER: Patrick Daly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs annie Daly

(Address): 932 S. Paca st

15 Filed MAY 24 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-22 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-19, 1921, to 5-22, 1921, that I last saw h(illegible) alive on 5-22, 1921, and that death occurred, on the date stated above, at 9 25-a. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1217 E. Lombard

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. L. Digiacomo, M. D.

5-23, 19 (Address) 418 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	5/25/1921
20 UNDERTAKER: James Di'grano & Son	ADDRESS: 1000 S Paca st

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dinkelspiel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54011 7 — D 54011

CERTIFICATE OF DEATH.

X45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME D. Edgar Dinkelspiel

(a) RESIDENCE. No. 307 W. 78th St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 days. How long in U. S., if of foreign birth? yrs. 1 mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Ethel S Dinkelspiel Southern Hotel City

6 DATE OF BIRTH (month, day, and year) Dec. 31st 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 154

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) California

PARENTS

10 NAME OF FATHER Lazarus Dinkelspiel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pauline Haas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisiana

14 Informant (Address) Johns Hopkins Hospital Baltimore

15 Filed MAY 24 1921 ROBERT A KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 - 1921

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1921, to May 23 -, 1921, that I last saw h[im] alive on May 23. 1921, and that death occurred, on the date stated above, at 3[10] P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas.
Sarcoma rt. shoulder.
Hydronephrosis

(duration) 5 yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 5/2/21

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation.

(Signed) H. A. Kelly, M. D.

5-23-1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York	5/24 1921
20 UNDERTAKER Jack Lewis 1411	ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 54012

D 54012 CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 W Hamby ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs John S Hurley

(a) RESIDENCE. No. 600 W Hamby ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 23 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 20 min.

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John S. Hurley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Annie Smart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John S. Hurley
(Address) 600 W Hamby

15 Filed MAY 24 1921, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 19 21, to May 23, 19 21, that I last saw h[illegible] alive on May 23, 19 21, and that death occurred, on the date stated above, at 6 20 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth
Mothers Toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Campbell M. D.

19 (Address) 6449 Hamilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	MAY 24 1921 19
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

189

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

John T. Logston

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54013

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Logston 64

CITY OF BALTIMORE: (No.) 1713 N. Regester (St.) 8 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Logston.

(a) RESIDENCE. No. 1713 N. Regester St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura C. Logston

6 DATE OF BIRTH (month, day, and year) Aug 10 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	9.	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Ret

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Logston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary C. Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Laura C. Logston

(Address) 1713 N. Regester St

15 Filed MAY 24 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1921

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1921, to May 23, 1921, that I last saw him alive on May 22, 1921, and that death occurred, on the date stated above, at 7:50 a m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia of Left Side - Hemorrhage

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

5/23/1921 (Address) 1223 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stone Chapel	May 25 1921
20 UNDERTAKER	ADDRESS
H. M. Cook	Md

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 54014

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1691-089

D 54014

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Poplar Grove ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Eleanor Gray.

(Residence in Baltimore: No. 910 Poplar Grove St.; — yrs. 6 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November (Month) 13 (Day), 1920 (Year)

7-AGE, ... yrs. 6 mos. 10 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... (Infant)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, R L Gray

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Margaret Flint

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt L Gray

(Address) 910 Poplar Grove

15- MAY 24 1921 ROBERT J. KRAUTER

Filed....., 191... Deputy Registrar. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 23rd (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1921, to May 23rd 1921, that I saw her alive on May 23 1921, and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

..... (Duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ... yrs. 1 mos. 1 ds.

(Signed) A. C. Grant M. D.

5/X/3., 1921 (Address) 1207 Poplar Grove

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, May 25., 1921.

20-UNDERTAKER William Cook

ADDRESS 502 E North ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54015

64 D 54015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 732 Poplar Grove St.: 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bowers

(a) RESIDENCE. No. 732 Poplar Grove St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. Lifetime How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. M. Bowers

6 DATE OF BIRTH (month, day, and year) March 25-1869 ~~not known~~

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
X	61	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife — 037

(b) General nature of industry, business, or establishment in which employed (or employer) General Courthouse

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Stuck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant C. M. Bowers Husband (Address) 732 Poplar Grove St

15 Filed MAY 24 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 6th, 1920, to May 23, 1921, that I last saw h[illegible] alive on May 22, 1921, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral-Hemorrhage

2 attack

(duration) ... yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteral Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis —

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lowe	May 19 24
20 UNDERTAKER	ADDRESS
Wm Cahoe	2026 E Monument

IS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54016

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 616 N Vincent ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charity Sollers

(a) RESIDENCE. No. 616 Vincent ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launderess OH

(b) General nature of industry, business, or establishment in which employed (or employer) Washing & Ironing

(c) Name of employer Day work

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Thomas Sollers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Tabb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Alexander Sollers
(Address) 616 Vincent St

15 Filed MAY 24 1921 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1921, to May 21, 1921.

that I last saw h[illegible] alive on May 21, 1921,

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? None

(Signed) E. William Frey, M. D.

5/22, 1921 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 24 1921
20 UNDERTAKER	ADDRESS 1140 W.
Brown & Freeland	Baltimore

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54017

CERTIFICATE OF DEATH.

151 D 54017

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 Fort Hill ST.; 70 WARD)

2-FULL NAME Baby Farmer

(a) RESIDENCE. No. 311 Fort Hill ST., 70 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of indostry, business, or establishment in which employed (or employer): 900

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Henry Farmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER Alice Berkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Henry Farmer
(Address) 311 Fort Hill Ave

15 Filed MAY 24 1921 ROBERT A. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1921, to May 23, 1921, that I last saw h— alive on May 23, 1921, and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) 15 minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. A. Knell, M. D.

5/23, 1921 (Address) Irvington.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	5/24 1921
20 UNDERTAKER	ADDRESS
Wm L Schwabs Bro	601 Pratt

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54018

CERTIFICATE OF DEATH.

170 D 54018

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Fredk Ave ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth L. Krumpholtz

(a) RESIDENCE. No. 2104 Fredericklock ST., 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustav Krumpholtz

6 DATE OF BIRTH (month, day, and year) June - 21 - 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of Industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Fredk Effenbrok (Address) 2104 Fredericklock Ave

15 Filed MAY 24 1921 ROBERT [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5- 22 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to May 22, 1921.

that I last saw h.r alive on May 22, 1921.

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

OVER

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Aneurism Arch of Aorta

Paralysis Vocal & Cord Left

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Ethelbert Hemmeter M. D.

5/23, 1921 (Address) 2000 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 26 1921
20 UNDERTAKER	ADDRESS
Geo L Schwab & Bro	2111 Fredk. Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history of Luco.
Cause of aneurysm
unknown.

AS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54019

CERTIFICATE OF DEATH.

1951001

D 54019

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST.) 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Rezek.

(Residence in Baltimore: No. 722 Greenmount Ave St.) 3 yrs., 1 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Baby

6-DATE OF BIRTH, April (Month) 2 (Day), 1918 (Year).

7-AGE, (3) yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....---
(b) General nature of industry, business, or establishment in which employed (or employer).....00

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Frank J. Rezek

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Sophia M. Jirsa

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Frank J. Rezek

(Address) 722 Greenmount Avenue

15- MAY 24 1921 ROBERT J. KRAUTER

Filed ..... 191.....(Date.) Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 22 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Rupture of Liver

4 days (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) H. Kirby Smith (Coroner) M. D.

5-22-, 191.. (Address) 4 E. Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery — DATE OF BURIAL, 5/25, 1921

20-UNDERTAKER Henry W. Mears & Son — ADDRESS 805 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54020 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54020

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Nicholson

(a) RESIDENCE. No. 3622 Elm Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

(Single, Married, Widowed, or Divorced (write the word))

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no.

6 DATE OF BIRTH (month, day, and year): Sept 19 1903

7 AGE: Years 18; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Lambert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Emma Lambert (Address) 3622 Elm Ave

15 Registrar

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MAY 24 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/23 1921

17

I HEREBY CERTIFY, That I attended deceased from 4/16, 1921, to 5/23, 1921, that I last saw him alive on 5/23, 1921, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of left lung

Tuberculosis of spine

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) Hunter Clin I M. D.

5/24, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wesley Chapel Carroll Co

DATE OF BURIAL: May 26 1921

20 UNDERTAKER: Chenoweth & Son

ADDRESS: Lexington Ave

TION is very important. See instructions on back of certificates.

Spec. 6-9-17—H. P. Co.—1000 Bkt.

D 54021 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

REGISTERED NO. 173

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Marsh

(a) RESIDENCE. No. 712 Carwell Ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Marsh

6 DATE OF BIRTH (month, day, and year): Sept 8-1893

7 AGE: Years 27 Months 8 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Railroader
(b) General nature of industry, business, or establishment in which employed (or employer): 073
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Samil. LeMarsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Carwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed . 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MAY 24 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23- 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19- 1921. to May 23- 1921.
that I last saw h-- alive on May 23- 1921.
and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Pyo-nephrosis.
Renal calculus
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Embolus
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 5/23/21

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H H Kerr M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	May 27 1921
20 UNDERTAKER	ADDRESS
Chenoweth Son	Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54022 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54022

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 W 36 ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Merriman

(a) RESIDENCE. No. 702 W 36 ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Merriman

6 DATE OF BIRTH (month, day, and year) June 22 1829

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	99	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jos Strickler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Shidle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rebecca Christopher (Address)

15 Filed MAY 21 1921, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1921

17 I HEREBY CERTIFY, That I attended deceased from May 9th, 1921, to May 22, 1921, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 705 P m.

The CAUSE OF DEATH* was as follows:

Apoplexia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 13 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A J Daniel, M. D

5-24 1921 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trenton Balto Co	May 26 1921
20 UNDERTAKER	ADDRESS
Chenowith & Son	Chestnut Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

D 54023

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 Mont-Juliet ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J Wetterstadt

(a) RESIDENCE. No. 938 Mont-Juliet ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Kunz

6 DATE OF BIRTH (month, day, and year) Sept Kunz

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Hodgins - Ben Plains, Pa

PARENTS

9 BIRTHPLACE (city or (State or country) Sept Kunz

10 NAME OF FATHER Sept Kunz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sept Kunz

12 MAIDEN NAME OF MOTHER Sept Kunz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sept Kunz

14 Informant Samuel Nicholson

(Address) 938 Mont-Juliet

15 Filed MAY 24 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17

I HEREBY CERTIFY, That I attended deceased from May 17th, 1921, to May 22nd, 1921, that I last saw h[illegible] alive on May 22nd, 1921, and that death occurred, on the date stated above, at 5.35 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo W Mumbrough M D, M. D.

(Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, Harford Rd

DATE OF BURIAL May 25th 1921

20 UNDERTAKER Wm Cook

ADDRESS 446 N.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. All information should be carefully supplied. CAUSE OF DEATH in plain (erms, so that it may be properly classified. Exact settlement TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54024

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54024

CERTIFICATE OF DEATH.

1132

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2717 Bernard ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Heitzell

(a) RESIDENCE. NO. 2717 Bernard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Heitzell

6 DATE OF BIRTH (month, day, and year) Dec 19 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miller 086

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Heitzell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Eliza Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md

14 Informant John H Heitzell

(Address) 2717 Bernard St

15 Filed MAY 24 1921 19.... Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1 1921 to May 23 1921

that I last saw h~~e~~ alive on May 23 1921

and that death occurred, on the date stated above, at 10 40 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Senile

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Kidney disease insufficiency

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. A. Buchanan M. D.

May 23 1921 (Address) 112 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St. Mary's Hampden May 25 1924

20 UNDERTAKER — ADDRESS

Geo Weber 502 E North Ave

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. Exact statement of place of death in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54025

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1008 Riverside Ave ST.: 24 WARD)

2-FULL NAME Elizabeth M Kelly

(a) RESIDENCE. NO. 1008 Riverside Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John W. Kelly

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) housework

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Lessner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Wildt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Edward Kelly

(Address) 1626 W Baltimore St

15 Filed MAY 24 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1921

17 I HEREBY CERTIFY, That I attended deceased from ? 1909, to May 23, 1921, that I last saw her alive on May 23, 1921, and that death occurred, on the date stated above, at 11:55 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 1/2 mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) C E Buxton, M. D.

5/24 1921 (Address) 3018 Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 27 1921
20 UNDERTAKER	ADDRESS
Margaret L. Flynn	1422 Light St.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54026

CERTIFICATE OF DEATH.

104

D 54026

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 Light St. ST.: 24 WARD)

2-FULL NAME Hamatina Mentis

(a) RESIDENCE. NO. 1741 Light ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 17 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town). (State or country) Balto md

PARENTS

10 NAME OF FATHER Constantan Mentis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Zorgia Georgi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Constantan Mentis (Address) 1741 Light St

15 Filed Robert P. Harrison, Registrar

MAY 24 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1921

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1921, to May 24, 1921, that I last saw h.. alive on May 23, 1921, and that death occurred, on the date stated above, at 5-a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Collapse

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A L Tinkleson M. D.

5/24 1921 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	May 20 1921
20 UNDERTAKER	ADDRESS
Margaret G Flynn	442 Light St

A. ... mation should be carefully supplied... CAUSE OF DEATH in plain terms, so that it may be properly classified... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54027

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 16 WARD)

2-FULL NAME Joseph M. Comer

(a) RESIDENCE. NO. 806 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 10 mos. 23 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Comer.

6 DATE OF BIRTH (month, day, and year) June 17 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	30	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer) at Mercy Hospital

(c) Name of employer

041

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Mrs. Mamie Comer. (Address) 806 N Mount St

15 Filed MAY 24 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 23 1921

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1921, to May 23, 1921, that I last saw h[illegible] alive on May 21, 1921, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 7 yrs. mos 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frederick L. Kearney, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL 5-26 1921

20 UNDERTAKER Mrs Chas A Rohde ADDRESS Harlington Md

B.—[illegible] should be carefully supplied. [illegible] may be properly classified. [illegible] mation should be carefully supplied. [illegible] so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54028

D 54028

CERTIFICATE OF DEATH.

105

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 Riverside Ave. WARD) 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis C. Ruff

(a) RESIDENCE. NO. 1136 Riverside Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7 - 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Straw Hat Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bergman Hoffheimer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Ruff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary R. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Charles Ruff
(Address) 1136 Riverside Ave

15 Filed MAY 23 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1921

17

I HEREBY CERTIFY, That I attended deceased from May 18, 1921, to May 22, 1921, that I last saw h[illegible] alive on May 22, 1921, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

5/22 1921 (Address) 279 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.A. Co. DATE OF BURIAL 5-24 1921

20 UNDERTAKER E + B Harle ADDRESS 115 E West St

Information should be carefully supplied. Answers must be complete, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 D 54029

D 54029

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2736 Harford Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgine Miller

(a) RESIDENCE. No. 2736 Harford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Peter A Miller

6 DATE OF BIRTH (month, day, and year) July 21 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	81			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home.
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Carl ~~Koenig~~ König

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Julius Meyer
(Address) 2736 Harford Ave

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1921, to May 21 1921, that I last saw her alive on May 21 1921, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Albert J. Kirk, M. D.

19 (Address) 2126 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Crem — DATE OF BURIAL: 5-26 1921

20 UNDERTAKER: Mrs. Chas A G Rohde — ADDRESS: Arlington Ave

MAY 3 1921

be properly executed. ... of certificates.

mation should be carefully supplied ... so that it may be ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of ce...

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54030

CERTIFICATE OF DEATH.

91 D 54030

REGISTERED NO. C.....

1-PLACE OF DEATH 815 Wellington St

CITY OF BALTIMORE: (No. ..... ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Margaret Horrigan.

(Residence in Baltimore: No. 815 Wellington St St.; 0 yrs., 3 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	

6-DATE OF BIRTH, Feb 4, 1911
(Month) (Day) (Year)

7-AGE, 0 yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James M. Horrigan

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Alice R. Moore.

13-BIRTHPLACE OF MOTHER (State or Country), Maysville Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. M. Horrigan

(Address) 815 Wellington St.

15- Robert F. Harrison

Filed..... 191..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24, 1911
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16th 1911, to May 24th 1911, that I saw h[illegible] alive on May 23rd 1911, and that death occurred, on the date stated above, at 12 46 A.m.

The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(Duration)....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) 11 yrs. 6 mos. 1 ds.

(Signed) [illegible] M. D.

May 24, 1911 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral. DATE OF BURIAL, May 26, 1911

20-UNDERTAKER Walter R. McNamee ADDRESS 801 Wellington St

N.B.—Every item of information should be carefully supplied, as the CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54031 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54031

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 N. East Ave ST.: 6 WARD)

2-FULL NAME Catherine Cunningham

(a) RESIDENCE. No 30 N. East ave. ST.; WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Cunningham

6 DATE OF BIRTH (month, day, and year): Apr. 17 1857

7 AGE — Years: 64 Months: 1 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER: Mike Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Miss Lee (gentleman)

(Address) 308 N. Edmondson

15 Filed , 19

Robert P. Harrison, Registrar

MAY 24 1921

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to May 22, 1921, that I last saw her alive on May 22, 1921, and that death occurred, on the date stated above, at 1 30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

CONTRIBUTORY (Secondary) Bronchial Asthma (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? (duration) 14 yrs. mos. ds.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Alan B Lemmon, M. D.

5 Jan. 1921 (Address) 718 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 5-25- 1921

20 UNDERTAKER: J. G. Inman — ADDRESS 3000 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous
Hypertrophy of heart.

D 54032 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54032

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. In front of 36 E. Cross St ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Concetta Irma Serio.

(Residence in Baltimore: No. 36 E. Cross St.

4 St.; yrs., 3 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, February 19th, 1917, 1
(Month) (Day) (Year)

7-AGE, 4 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None. 100
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Anthony Serio.

11-BIRTHPLACE OF FATHER (State or Country). Italy.

12-MAIDEN NAME OF MOTHER Anna Obst.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Serio (father)

(Address) 36 E. Cross St.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

MAY 7 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 23rd. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed about the body.
Accidentally knocked down and
run over by auto truck.
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) Wm. H. Feinhardt M. D.
(Coroner.)

May 24, 1921 (Address) 1217 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 5/25, 1921

20-UNDERTAKER J. F. Falconer ADDRESS 1011 Eighth Ave

N.B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54033

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 E. Park Ave. Raspelourg ST.; ... WARD)

2-FULL NAME Annie E. Powell

(a) RESIDENCE. No. 120 E. Park ave. Raspelburg ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. A. Powell

6 DATE OF BIRTH (month, day, and year) Aug. 15th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick
(State or country) Maryland

PARENTS

10 NAME OF FATHER David Cole

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14 Informant Howard A. Dixon
(Address) 120 E. Park Ave. Raspelburg

15 Filed MAY 25 1921 ROBERT I. [illegible] Registrar
Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from December 1st, 1921, to May 24th, 1924, that I last saw h... alive on May 23rd, 1924, and that death occurred, on the date stated above, at 1130 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) P. E. Gilly, M. D.

May 25 1924 (Address) 120 E. Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery Frederick Md.	May 27 21

20 UNDERTAKER Frech Funeral Home — ADDRESS Fullerton Md.

mation should be carefully answered in all its terms, so that it may be properly
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54034
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

172 D 54034
REGISTERED NO. C

CITY OF BALTIMORE: (No. 1332 W Mortar St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget Santry

(Residence in Baltimore: No. 1332 W. North Ave St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, March (Month) 14th (Day) 1850 (Year)

7-AGE, 70 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Nothing
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Jeremiah Cashman

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Sweeney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Santry

(Address) 1332 W. Mortar St

15- Filed MAY 25 1921 191... ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 23rd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1921, to May 23 1921, that I saw her alive on May 23rd 1921, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

1. Hypostatic Pneumonia
2. Shock
(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Intracapsular Fracture of Femur Impacted
(Duration) ....yrs. ....mos. 7 ds.

(Signed) Joseph D. Saunders M. D.

May 24th 1921 (Address) 714 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	May 26 1921
20-UNDERTAKER Martin Tuskey & Son	ADDRESS 827 N Wolfe

N.B.—Every item of information should be given so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

✓ 1921

D 54035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54035

CERTIFICATE OF DEATH.

REGISTERED NO. 79 835

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie W. Ball

(a) RESIDENCE. No. #1316 N. Mount St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	1	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Barber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Husband (Address) 1316 N Mount St

15 Filed MAY 25 1921 ROBERT F. [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1921, to May 23, 1921, that I last saw him alive on May 23, 1921, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis & Mitral Insufficiency
Acute Cardiac Dilatation

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. Meyer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 25 1921
20 UNDERTAKER	ADDRESS
Lawrence E. Smith	1364 W. Cary

N. B.—Information should be carefully supplied. All the items should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54036 ✓ 159 D 54036

D 54036

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 916 Cathedral ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Augustus Rowland.

(Residence in Baltimore: No. 915 Cathedral St. St.; 18 yrs., 10 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, July (Month) 18 (Day), 1892 (Year)

7-AGE, 28 yrs. 10 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Electrical
(b) General nature of industry, business, or establishment in which employed (or employer)..... Engineer

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. Prof. Henry A Rowland

11-BIRTHPLACE OF FATHER (State or Country). New Jersey

12-MAIDEN NAME OF MOTHER Henrietta Morrison

13-BIRTHPLACE OF MOTHER (State or Country). Balto- Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Henrietta Rowland.

(Address) 915 Cathedral St.

15- MAY 25 1921 191.....

LOUIS E KRAUTH
Burial Permit Recorder

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Gun shot wound
Head
(Duration).....yrs. Instant mos.....ds.
CONTRIBUTORY (Secondary) Shock. Instant
(Duration).....yrs.....mos.....ds.

(Signed) Geo Lewis Keating M. D.
(Coroner.)
5/24/21, 191... (Address) 1423 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park | DATE OF BURIAL, May 25 1921

20-UNDERTAKER Henry W Perkins & Sons Co | ADDRESS 1911 Eutaw Pl.

N.B.—Every item of information should be carefully given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 54037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54037

CERTIFICATE OF DEATH

REGISTERED NO. 64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Schaffer ave ST.: Hazelton 27 WARD)

2-FULL NAME Robert F Holland

(a) RESIDENCE. No. 8 Schaffer ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE) Joan C. Holland

6 DATE OF BIRTH (month, day, and year) August 7th 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Margaret Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Mrs Virginia L Curtain

(Address) 10 8 Schaffer

EDWIN A. HEUISLER

15 Filed MAY 25 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 13th, 1921, to May 24th, 1921, that I last saw him alive on May 23rd, 1921, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Arteria-sclerosis.
Chronic Interstitial Nephritis
(duration) 5 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) — yrs. — mos. one ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary.

(Signed) Steuart F. Stieleman M. D.

May 24 1921 (Address) 1227 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 26th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1146 E Monument

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be correctly stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF BURIAL is very important. See instructions on back of certificates.

D 54038

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

6-092 D 54038

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3015 E. Baltimore St.; 1 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary B. Adams.

(Residence in Baltimore: No. 2927 Eastern Ave. St.; 1yr. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: May (Month) 12 (Day), 1919 (Year)

7 AGE: 1 yrs. 9 mos. 13 ds. If LESS than 1 day, ... hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Adams Jr.

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Madelin Smith

13 BIRTHPLACE OF MOTHER (State or country): Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles J. Adams.
(Address) 2927 Eastern Ave,

15 Filed MAY 25 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 25 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1921. to. May 25 1921.
that I saw her alive on May 24, 1921.
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:

Bilateral Pneumonitis. Nov

(Duration — yrs. — mos. 10 ds

Contributory (SECONDARY)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Allen C Bertram M. D.
May 25, 1921 (Address) 339 E. Balt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: May 28, 1921

20 UNDERTAKER: Lilly and Zeiler ADDRESS: 403 S. Wolfe St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54039

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54039

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3031 O. Donnell ST.: 1 WARD)

2-FULL NAME John Bruns

(a) RESIDENCE: NO. 3031 O. Donnell ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1/2 Hours ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May. 24th 1921

7 AGE	Years	Months	Days	If LESS than 1 day 1/2 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child 600
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Frank L. Bruns
11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)
12 MAIDEN NAME OF MOTHER Marion D. Horney
13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Marion D. Bruns (Mother)
(Address) 3031 O. Donnell St.

15 Filed MAY 25 1921 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/24 1921

17 I HEREBY CERTIFY, That I attended deceased from
on 5/24 1921, to , 19 ,
that I last saw h alive on May 24 1921,
and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth
5th month.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Kaelusky, M. D.
5/24 1921 (Address) 3030 O Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL May 25 1921

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54040 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54040

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 N. Robinson ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bowling

(a) RESIDENCE. NO. 422 N. Robinson ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Richard H. Bowling

6 DATE OF BIRTH (month, day, and year) Nov. 15th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Liverpool England

PARENTS

10 NAME OF FATHER Daniel Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Thomas E. Bowlingston
(Address) 2911 Dillon St.

15 Filed MAY 25 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1921

17 I HEREBY CERTIFY, That I attended deceased from 5/12, 1921, to 5/23, 1921, that I last saw h alive on 5/21, 1921, and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

(a) Endocarditis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Franck, M. D.

5-24 1921 (Address) 1139 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 26 1921

20 UNDERTAKER Lilly & Zieler ADDRESS 403 S. Wolfe St.

Burial Permit Clerk

N. B.—Information should be carefully supplied. All items should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54041

CERTIFICATE OF DEATH.

160 D 54041
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Agnes Hospital ST.; 7-5 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Weik
(Residence in Baltimore: No. R R. ave Wilhelm Park St.; yrs. 29 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 26 (Day), 1894 (Year)

7-AGE, 26 yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman 073
(b) General nature of industry, business, or establishment in which employed (or employer)..... U.S.R.R. Co.

9-BIRTHPLACE, (State or Country) Balto City

PARENTS.
10-NAME OF FATHER, Harry Weik
11-BIRTHPLACE OF FATHER (State or Country), Balto City.
12-MAIDEN NAME OF MOTHER Anna Nicholas
13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred Nicholas
(Address) 2670 Wilkens Ave

15-
Filed MAY 25 1921 19.. ROBERT E. KRAUTH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 23 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.
The CAUSE OF DEATH* was as follows:
Searing of trachea & tissues & Skin & Suicide while in
neck (Duration) yrs. mos. 8 ds.
despondency
CONTRIBUTORY (Secondary) Suspirating Pneumonia (Duration) yrs. mos. 4 ds.
(Signed) James M. Benton M. D.
May 24, 1921 (Coroner.) (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos. 7 ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
R.R. ave Wilhelm Park
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery
DATE OF BURIAL, May 25/ 19 21

20-UNDERTAKER F.B. Wippert ADDRESS 2236 Frederick Ave

N.B.—Every item of information should be carefully supplied. AGE must be given. Exact statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 64044 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54041

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.; WARD), Charles & Wilkens. Ave

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelm Pk. R.R. Anx

(a) RESIDENCE. NO. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
M.	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26 1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Car - tour.
(b) General nature of industry, business, or establishment in which employed (or employer) W E Ry Co
(c) Name of employer Md

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Deceased
11 BIRTHPLACE OF FATHER (city or town) Detroit Mich
(State or country)
12 MAIDEN NAME OF MOTHER Anna Neuhaus
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Ernest Nicholas
(Address) 264 Wilkens Ave

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-23 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-15, 1921, to 5-23, 1921, that I last saw h alive on 5-23, 1921, and that death occurred, on the date stated above, at 9:45 A m.

The CAUSE OF DEATH* was as follows:

Attempted suicide
Laceration of neck, severing
esophagus & trachea
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pneumonia - bronchial
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-15-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm H Craig M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Mt Lebanon Cemetery	May 25 '21
20 UNDERTAKER	ADDRESS
F H Metzger	93 S Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied

Dr Ruland
#28 – Edmondson Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54042

D 54042

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 932 N. Payson ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret H. Spanner

(a) RESIDENCE. NO. 932 N. Payson ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 10 mos. 1 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city ~~or town~~) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Andrew J. Connelly

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ida Jones

13 BIRTHPLACE OF MOTHER (city or ~~town~~) Baltimore
(State or country)

14 Informant Andrew J. Connelly
(Address) 932 N. Payson St.

15 Filed MAY 25 1921 [illegible] LAUTER Registrar

Burial Permit Oleff

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1921

17

I HEREBY CERTIFY, That I attended deceased from December 1, 1920, to May 23, 1921, that I last saw her alive on May 23, 1921, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

1 year
(duration) yrs. — mos. ds.

CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Chester Ruland, M. D.

5-24 1921 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 26 1921

20 UNDERTAKER Martin Fahey & Sons ADDRESS 827 W. North Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statements may be made in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements may be made in back of certificates. See instructions on back. TION is very important. See instructions on back.

Baltimore, Md. August 23, 1921.

I do hereby make oath that the state given on Certificate of Death #D-54042, the duration of illness being given as two years, is not correct, same should be recorded as of one year's duration. Name of deceased - Margaret H. Spamer.

Chester Richards, M.D.
Physician.

Subscribed and sworn to before me this 23d of August, 1921.

Reed Gaither.
Notary Public.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 54043
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915 W. Franklin ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Wescott

(a) RESIDENCE. No. 1915 W. Franklin ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — — — — — —

6 DATE OF BIRTH (month, day, and year) Feb 26, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65 yrs	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md

PARENTS

10 NAME OF FATHER Philip A. Wagner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Gettier

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Etta Cochrane
(Address) 1915 W. Franklin st.

15 Filed MAY 25 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1921

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1917, to May 24, 1921, that I last saw h[illegible] alive on May 23, 1921, and that death occurred, on the date stated above, at 7 38 m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) ✓ yrs. ✓ mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease

(duration) 4 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Nancy C. Cochran, M. D.

(Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 27 1921
20 UNDERTAKER	ADDRESS
Jos Sanders & Son	217 S. Paca st

N. B.—WRITE PLAINLY, with ink. AGE should be carefully supplied. Any information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54044

CERTIFICATE OF DEATH.

31 D 54044

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Overton

(a) RESIDENCE. No. 927 N. Calhoun St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer: Leslie Ball-5-years

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Joseph Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Nancy Hughlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records.
(Address): New City Hospital.

15 Filed MAY 25 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

t6 DATE OF DEATH (month, day, and year): May 22, 1921

t7 I HEREBY CERTIFY, That I attended deceased from April 22, 1921 to May 22, 1921 that I last saw her alive on May 21, 1921 and that death occurred, on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary): Tuberculous Peritonitis

(duration) [illegible] yrs. 1 mos. — ds.

t8 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Claud C. Burton, M. D.

5-22-21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 25 1921

20 UNDERTAKER: Jere Robert A Elliott ADDRESS 1725 Ashland Ave

N. B.—Information should be carefully supplied. Answers must be full and complete, so that it may be properly classified. Particularly CAUSE OF DEATH in plain terms

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54045

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54045

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 S. Paca ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Yeakle

(a) RESIDENCE. NO. 813 S. Paca St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Yeakle

6 DATE OF BIRTH (month, day, and year) May 4 th 1859

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
62		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Gotlieb Yeakle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Buchner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Fleury (Address) 813 S Paca St

15 Filed MAY 25 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1921

17

I HEREBY CERTIFY, That I attended deceased from May 22 1921, to May 24, 1921, that I last saw him alive on May 23, 1921, and that death occurred, on the date stated above, at 1 PM m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Whitridge Hoag, M. D.

May 25 1921 (Address) 709 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral cemetery	May Thurs 26 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

CAUSE OF DEATH in plain terms, so that it may be understood by a layman. See that it is written in ink or typewritten. Every question must be answered. Every blank must be filled. Every item of information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54046

CERTIFICATE OF DEATH.

37

D 54046

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balto General Hosp ST. 216 (WARD)

2-FULL NAME Mrs. Lula Porter

(a) RESIDENCE. NO. 1500 Webster ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Howard A. Porter

6 DATE OF BIRTH (month, day, and year) August 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Ingram

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant South Baltimore Gen. Hospital
(Address) 1213 Light St.

15 FILED MAY 25 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1921

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1921, to May 24, 1921, that I last saw h.er alive on May 24, 1921, and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Uremia. (of Brain)

Undetermined (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Syphilis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P. R. Reynolds, M. D.

, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	May 26 1921
20 UNDERTAKER	ADDRESS
E. V. Fanning & Son	1460 Battery ave.

N. B.—WRITE PLAINLY, with pen and ink. All items must be carefully supplied. Any information should be carefully supplied. Any information should be carefully supplied, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54047

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54047

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2034 W Lanvale ST.) (16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Virginia Taylor

(a) RESIDENCE. NO. 2034 W Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. P. Taylor

6 DATE OF BIRTH (month, day, and year) Nov. 29 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fox Children James City Co. Va

9 BIRTHPLACE (city or town) (State or country) James City Co. Va

PARENTS

10 NAME OF FATHER Alex. Hawkins Va

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary B Taylor Va

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Wm Taylor 2034 W Lanvale St

15 Filed MAY 25 1921 19 Robert P. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20 1921, to May 24 1921, that I last saw h[er] alive on May 24 1921, and that death occurred, un the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Indigestion, Heart failure

22 Yrs. 2 Mos. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old Maxtar Locust Terrace (duration) 2½ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) Ed Smith, M. D.

5/24/1921 (Address) 1605 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Lighwood, James City Co. Va May 25 1921

20 UNDERTAKER ADDRESS

Geo W Little 2700 Edmondson Ave

mation should be given in plain terms, so that it may be understood by the public generally. CAUSE OF DEATH in plain terms, so that it may be understood by the public generally. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54048

CERTIFICATE OF DEATH.

79

D 54048

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 Etting ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Lillian Franklin

(a) RESIDENCE. No. 1105 Etting ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry P. Franklin

6 DATE OF BIRTH (month, day, and year) Jan 10-76

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer Southern Life Ins. Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Harry P. Franklin
(Address) 1105 Etting St

15 Filed [illegible] Registrar

MAY 25 1921

Robert F. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19th, 1921, to May 23rd, 1921, that I last saw her alive on May 22nd, 1921, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical & Clinical

(Signed) Geo. H. Lullenbeck, M. D.

May 24th 1921 (Address) 225 N. Monroe Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	May 26th 1921
20 UNDERTAKER	ADDRESS
Jno. A. Holland	1231 Lemmon Hill Ave

mation should be given in plain terms, so that it may be understood. CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54049 ✓ 120 D 54049

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH St Agnes Hosp

CITY OF BALTIMORE: (NO. Wilkins Ave ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Cyrus T. Driver

(a) RESIDENCE. NO. 355 Woodyear ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 ~~Single, Married, Widowed,~~ or Divorced (write the word): Married Divorced

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Driver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Kathrine Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Blanche Driver 1329 Scott

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

MAY 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-15, 1921, to 5-24, 1921.

that I last saw him alive on 5-24, 1921.

and that death occurred, on the date stated above, at 12 mid.

The CAUSE OF DEATH* was as follows:

Infection Carbuncle

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of 5-15-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Craig, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 28 1921
20 UNDERTAKER	ADDRESS
William Cook	502 E North

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D 54050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54050

CERTIFICATE OF DEATH.

50

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Summit Av ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Montgomery

(Residence in Baltimore: No. 1827 Summit Av St.; 38 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 10 (Month) 10 (Day), 1873 (Year)

7-AGE, 48 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Postman
(b) General nature of industry, business, or establishment in which employed (or employer)..... U. S. 086

9-BIRTHPLACE, (State or Country), Washington - D.C

PARENTS.

10-NAME OF FATHER, Jno. E. Montgomery

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ellen Wilks

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Montgomery

(Address) 1827 Summit St -

15-

Filed..... 1921 Robert P. Harrison, Registrar.

MAY 25 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 25th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2nd 1919, to May 25th 1921, that I saw him alive on May 25th 1921, and that death occurred, on the date stated above, at 8-20 Am.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 5 yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Gangrene of L leg

(Duration).....yrs.....mos.....ds.

(Signed) H. A. Hammett M. D.

May 25th, 1921. (Address) 1929 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 10 mos.....ds. In the State 49 yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1827 Summit St

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, May 27, 1921

20-UNDERTAKER William Cook

ADDRESS 502 E. Ninth St

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

14739 3. D 54051

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54051

CERTIFICATE OF DEATH.

X 37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.:) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Apgar.

(a) RESIDENCE. No. Bier Apartment, Niagra Falls. St., Ward. Niagara Falls N. Y.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 13 ds. ✓ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C. Apgar. (Brother) Burrsburt Pa

6 DATE OF BIRTH (month, day, and year) March 17, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. J.

PARENTS

10 NAME OF FATHER Edward C. Apgar.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Eva Swick,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant (Address) Johns Hopkins Hospital Records.

15 Filed MAY 25 1921, 19 Robert F. Harrison, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1921, to May 21, 1921, that I last saw him alive on May 21, 1921, and that death occurred, on the date stated above, at 1 40 A. m.

The CAUSE OF DEATH* was as follows:

Tabes dorsalis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. R. Mason, M. D.

5.25, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camden N. J. DATE OF BURIAL 5/25 1921

20 UNDERTAKER Wm. E. Hilyard ADDRESS 424 S. Broadway

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54052

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 54052

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 N. Broadway ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia A Streett

(a) RESIDENCE. NO. 1713 N. Broadway ~~ST.~~ WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Shadrach Streett

6 DATE OF BIRTH (month, day, and year) May 29th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) HOH

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Caleb Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Ann Barrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant Miss Allie Streett
(Address) 1713 N. Broadway

15 Filed MAY 25 1921 ROBERT J. CRAWFORD Registrar
Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1920, to May 25, 1921, that I last saw h~~er~~ alive on May 23, 1921, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) yrs. 11 mos. 25 ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1107 Lexington Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 27th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

N. B.—Write plainly. All information should be carefully supplied. Attention is called to the fact that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54053 ✓

D 54053

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital St. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerge Durst

(a) RESIDENCE. No. 506 N Carrollton St. East WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19th

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John M. Durst

11 BIRTHPLACE OF FATHER (city or town) Balto md (State or country)

12 MAIDEN NAME OF MOTHER Susan Henry

13 BIRTHPLACE OF MOTHER (city or town) Balto md (State or country)

14 Informant Mrs. J. W. Kinn

(Address) 506 N Carrollton Ave

15 Filed MAY 26 1921 ROBERT F. CARTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25/ 1921

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to May 25, 1921, that I last saw h.. alive on May 25, 1921, and that death occurred, on the date stated above, at 5:a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pt's symptoms

(Signed) L. B. Bramhall, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	5-27- 1921
20 UNDERTAKER	ADDRESS 517 N.
H C Brauning Sons	Schroeder St

CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54054

D 54054

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 39 E. Randall St. ST.: 72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Squires

(a) RESIDENCE. No. 39 E. Randall St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Abt. 20 yrs. mos. ds. How long in U. S., if of foreign birth? 78 yrs 11 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Squires

6 DATE OF BIRTH (month, day, and year) May 29 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co. Md.

PARENTS

10 NAME OF FATHER John Eaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Minnie Squires
(Address) 39 E. Randall St.

15 Filed MAY 26 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10 1921, to May 24 1921, that I last saw h[illegible] alive on May 24 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:
Cardiac Asthma.

0727

(duration) yrs. mo. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Boorhaus, M. D.

1921 (Address) 1 E Ran

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk. Cem.	May 27 1921
20 UNDERTAKER	ADDRESS
J. Fred McCully	130 E. Fay

INFORMATION should be given in plain terms, so that it may be readily understood. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be readily understood. See instructions on back of certificates.
TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No hemorrhage. No chronic organic heart disease. Sister makes.

D 54055

Spec.—6-9-19—H. P. Co.—1000 Pks.

D 54055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 215 South 1st ST. Brooklyn 2nd WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah M. Junker

(a) RESIDENCE. NO. 215 South 1st ST. Brooklyn 2nd WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3/4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 2 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Brooklyn
(State or country) Md

PARENTS

10 NAME OF FATHER Harry J. Junker

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna E. Garrett

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co
(State or country) Md

14 Informant Harry J. Junker
(Address) 215 S. 1st Brooklyn Md

15 MAY 26 1921 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1921, to May 25, 1921, that I last saw h[illegible] alive on May 24, 19..., and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O. Brode M. D.

, 1921 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	26 19
20 UNDERTAKER JOHN F. DENNY	ADDRESS [illegible]

mation should be given in plain terms, so that it may be understood by the general public. Do not use abbreviations or technical terms. CAUSE OF DEATH in plain terms, so that it may be understood by the general public. Do not use abbreviations or technical terms. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54056

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO Municipal Tuberculosis Hospital ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Gordon

(a) RESIDENCE. NO. 1406 Hempel Alley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Gordon

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Patrick Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Norman Patrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hoppital Records (Address) M.T.H.

15 Filed MAY 26 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1921, to May 23, 1921, that I last saw her alive on May 22, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydropneumothorax

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) le X Fahndrich, M. D.

5-23-21 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL MAY 26 1921

20 UNDERTAKER

ADDRESS

Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54057

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 D 54057

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Brookfield St.; 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Anna Barnes (Barnes)

(Residence in Baltimore: No. 2104 Brookfield ave St. 80 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	widow

6-DATE OF BIRTH April 20, 1843
(Month) (Day) (Year)

7-AGE, 79 yrs. mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home duties
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Dorchester Co Md

PARENTS.

10-NAME OF FATHER, Wm Barnes

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Laura E Scott

(Address) 2104 Brookfield ave

15- Filed MAY 26 1921, 191... ROBERT F KRAUTER Registrar

Burial

CAUSE OF DEATH to be plainly written. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 25, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 1921, to May 25 1921, that I saw her alive on May 24 1921, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Multiple Neuritis
Terminal Bronchitis

(Duration) 3 mos. 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Chas R Davis M. D.

....., 191... (Address) 2105 Brookfield ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Roland Ave — DATE OF BURIAL, May 27 1921

20-UNDERTAKER Wm Cook & Son — ADDRESS E North

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54058

CERTIFICATE OF DEATH.

120 D 54058

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N Mt Street WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M Patterson

(a) RESIDENCE. No. 1034 Mt Street WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma L Patterson

6 DATE OF BIRTH (month, day, and year) Oct 15 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Gibson W Patterson

11 BIRTHPLACE OF FATHER (city or town) Washington D C
(State or country)

12 MAIDEN NAME OF MOTHER Martha Bruce

13 BIRTHPLACE OF MOTHER (city or town) Washington D C
(State or country)

14 Informant Emma L Patterson
(Address) 1034 Mt Street

15 Filed MAY 26 1921 ROBERT F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1921, to May 25, 1921, that I last saw him alive on May 23, 1921, and that death occurred, on the date stated above, at 2.15 A, m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno F Fisher, M. D.

May 26, 1921 (Address) 1823 N Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
NW Cleve Funeral	May 28 1921

20 UNDERTAKER Robt J Turner & Bro

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information should be entered on back of certificates. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54059

CERTIFICATE OF DEATH.

28 D 54059

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 21 WARD)

2-FULL NAME Lesley Norwood

(a) RESIDENCE. No. 759 Dover st. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

048

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Daniel Norwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Eva Stokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records
(Address) U.T.H.

15 Filed MAY 26 1921 19 ROBERT J. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1921

17

I HEREBY CERTIFY, That I attended deceased from March 30, 1921, to May 23, 1921.

that I last saw him alive on May 23, 1921.

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. P. Aigney, M. D.

5-23-21 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 26 1921

Commissioner Health.

CAUSE OF DEATH in plain terms, so that a definite and satisfactory classification may be made. Indefinite terms, such as "Heart Failure," "Exhaustion," "Old Age," "Senility," "Infirmities of Age," "Natural Causes," "Septicemia," "Blood Poisoning," "Pyemia," "Uremia," "Convulsions," "Paralysis," "Tumor," "Cancer," "Abscess," "Meningitis," "Hemorrhage," "Asphyxia," "Suffocation," "Drowning," "Fracture," "Injuries," "Shock," "Collapse," "Coma," "Unknown," are not sufficient. If from violence, state the MEANS and NATURE OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. If from disease, state the DISEASE CAUSING DEATH, and not the mode of dying. If from childbirth, state whether the woman was single or married. If from accident, state the date of injury. If from any cause specified in the last 12 months of pregnancy, state the number of months pregnant. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54060 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54060

CERTIFICATE OF DEATH. X 137

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Goldie Fisher

(a) RESIDENCE. No. Ellicott City, Md ST.. WARD. Ellicott City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Fisher

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Frederick Zeigler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Catara Zeigler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Frank Fisher (Address) Ellicott City Md

15 MAY 26 1921 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23rd, 1921, to May 24th, 1921, that I last saw h-e alive on May 24th, 1921, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 24th 1921

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Geo. Lee Wiesing, M. D.

, 19. (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Johns cem Ellicott City	May 27 1921
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

54061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 54061

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST.: 15 WARD)

2-FULL NAME Lydia Thompson

(a) RESIDENCE. NO. 1345 N. Caroline ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bay View Hospital Balto, Md

15 MAY 26 1921 ROBERT F. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1921, to May 22, 1921, that I last saw h[illegible] alive on May 22 1921, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia & Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical findings.

(Signed) H. Goldsmith M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rosehill Cem. Co. DATE OF BURIAL MAY 26 1921

20 UNDERTAKER JAMES H. DENNIS & SON

1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54062

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D 54062

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 184 N. Hanburg ST.; 22nd WARD)

2-FULL NAME Mrs. Alberta Virginia German.

(a) RESIDENCE. No. 184 N Hanburg ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick German.

6 DATE OF BIRTH (month, day, and year) Feb 28- 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	2	26	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cambridge Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Elsie German Mayer
(Address) 184 N. Hanburg St.

15 MAY 26 1921 STREET [illegible] REGISTER Registrar Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-21, 1921, to 5-24, 1921, that I last saw her alive on 5 24, 1921, and that death occurred, on the date stated above, at 4 15 P. m.

The CAUSE OF DEATH* was as follows:

1 Bilateral Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) Wallace Bell, M. D.

, 19 (Address) 1224 No. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 29 1921
20 UNDERTAKER	ADDRESS
J W Brown & Son	108 W Monty

CAUSE OF DEATH in plain terms, so that it may be understood by the general public. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54063 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 54063
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N Glover St. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Pauline Henrietta Thiele.

(a) RESIDENCE. NO. 517 N Glover St. ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 30 yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Oswald Frank Thiele

6 DATE OF BIRTH (month, day, and year): May 27th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of Industry, business, or establishment in which employed (or employer): — 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Poldie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Poldie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Oswald Thiele
(Address) 517 Glover St.

15 FILED: MAY 26 1921 ROBERT F. [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1921, to May 25th, 1921, that I last saw h[illegible] alive on May 25th, 1921, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

1 Carcinoma of liver

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

19 (Address) 4016 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: May 28 1921

20 UNDERTAKER: C. W. Dill

ADDRESS 3109 Frdk: Ave:

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54064 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54064

CERTIFICATE OF DEATH.

47

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S. Hare ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Marion Bruff.

(a) RESIDENCE. No. 19 S. Hare ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie E. Bruff

6 DATE OF BIRTH (month, day, and year) May 2 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Purchasing Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Bruff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co, Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Katie E. Bruff (Address) 19 S. Hare St

15 Filed MAY 26 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1921

17

I HEREBY CERTIFY, That I attended deceased from May 22, 1921, to May 24, 1921, that I last saw h[illegible] alive on May 23, 1921, and that death occurred, on the date stated above, at 6 30 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) R Pneumonia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John H. Ohnsm M. D.

May 24 1921 (Address) 35 N. Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	May 27 1921
20 UNDERTAKER	ADDRESS
H. Sanders & Sons	1710 Fleet St

mation should be entered, so that it may be properly ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54065

CERTIFICATE OF DEATH.

28 D 54065

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2340 N. Calvert ST., 12 WARD)

2-FULL NAME Irwin J. Nicols

(a) RESIDENCE NO. 2340 N. Calvert ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily W. Nichols

6 DATE OF BIRTH (month, day, and year) May 10, 1862

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
59	—	15	

8 OCCUPATION OF DECEASED 066

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Merchants

(c) Name of employer Daniel Miller Co.

9 BIRTHPLACE (city or town) (State or country) St. Pauls, Kent Co. Md.

PARENTS

10 NAME OF FATHER Jeremiah Nicols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Burgess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Emily W Nichols
(Address) 2340 N Calvert

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

V 2 61921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 25. 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr. 8, 1921, to May 25, 1921, that I last saw him alive on May 25, 1921, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

indefinite (duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Martin F. Sloan, M. D.

5-26, 1921 (Address) 414 Red Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cem, Kent Co Md	May 27 1921
20 UNDERTAKER	ADDRESS
John O. Mitchell	120 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54066

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54066

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 Ramsay St. St. 24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Heinzmann

(a) RESIDENCE. No. 708 Ramsay St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Heinzmann

6 DATE OF BIRTH (month, day, and year) March 23" 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) M. Gault Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Heinzmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Annie Heinzmann (Address) 708 Ramsay St.

15 Filed MAY 28 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25" 19 21

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible], to May 25, 19 21, that I last saw h[illegible] alive on May 24, 19 21, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 3 mos. [illegible] ds.

CONTRIBUTORY (Secondary) Senile Pneumonia

(duration) yrs. 3 mos. [illegible] ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Boyd M. D.

(Address) 502 S. Columbus Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 27 1921
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54067

CERTIFICATE OF DEATH.

1

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 E Chase ST.; 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Hintenach

(a) RESIDENCE. NO. 918 E Chase ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? Ryrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Geo P. Hintenach

6 DATE OF BIRTH (month, day, and year) Apl 16th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Marys
(State or country) Penna

PARENTS

10 NAME OF FATHER Bernard Weidenboerner

11 BIRTHPLACE OF FATHER (city or town) Hessen
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Ann Engel

13 BIRTHPLACE OF MOTHER (city or town) Baden
(State or country) Germany

14 Informant Mrs. Henry Fuhr
(Address) St Marys Elk Co Pa

15 Filed MAY 23 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th 1921

17

I HEREBY CERTIFY, That I attended deceased from May 20th, 1921, to May 24th, 1921, that I last saw h alive on May 24th, 1921, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage causing Hemiplegia & Coma

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Ch. Valv. Endocarditis Uncertain

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jefferson Bell M. D.

5/24 1921 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	5/27/21
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave.

mation should be carefully supplied. Exact information should be properly classified. Exact information should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54068

110

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2107 Penrose ave ST.: 20 WARD)

2-FULL NAME Rose Barth

(a) RESIDENCE. NO. 2107 Penrose ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~ (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Barth

6 DATE OF BIRTH (month, day, and year) Mar 27-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~000~~

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER George Urban

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Anna Barth.

(Address) 2107 Penrose

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

MAY 26 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25th 1921

17 I HEREBY CERTIFY, That I attended deceased from January 21st 1921, to May 25th 1921, that I last saw her alive on May 24th 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Splanchnoptosis & Arterio-sclerosis

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Hypostrophy & Mitral Regurgitation of heart

(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? At 1917 Jackson St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Kleibel M. D.

5/26. 1921 (Address) 1224 Hanover Sto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem A. A. Co.	May 27 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 54069 D 54069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 182

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1076 Fall Road. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles Leonard Starke

(Residence in Baltimore: No. 1076 Falls Road St.; yrs., 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLY, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug (Month) 26 (Day), 1866 (Year)

7-AGE 54 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ret.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Stark

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Susan Moore

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Stark.

(Address) 1076 Falls road

15- Robert P. Harrison,

Filed....., 191.....

MAY 26 1921 Burial Permit Clerk, Registrar.

NB.—Every item of information should be given so that it may be properly classified. CAUSE OF DEATH in plain terms, as that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 25th (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wound through heart Homicidal

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) John Morrissey, M. D. (Coroner.)

May 26, 1921. (Address) 3532 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, G. Mays Hampden DATE OF BURIAL May 28, 1921

20-UNDERTAKER H. S. Marshall ADDRESS 353 Fallsd

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54070

CERTIFICATE OF DEATH.

X 74 D 54070

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hospital ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Lefcourt

(a) RESIDENCE. No. 721 West ave N York City ST., WARD. New York N. Y.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) [illegible] 1907.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Chas S. Lefcourt

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rae Isen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant (Address) John Hopkins Hospital Record

15 MAY 26 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11— 1921 to May 26 1921

that I last saw h.im alive on May 26 — 1921

and that death occurred, on the date stated above, at 7-0 m.

The CAUSE OF DEATH* was as follows:

Desir tumor.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Medullary compression.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted If not at place of death? Do not know.

Did an operation precede death? Yes Date of 5/26/21.

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Harry W Bloth M. D.

19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York — DATE OF BURIAL May 27 1921

20 UNDERTAKER Leland Sondheim — ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that a correct classification may be made. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54071

CERTIFICATE OF DEATH.

5-28

D 54071

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Brown

(a) RESIDENCE. NO. 1223 Orleans st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Chas. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Connecticut

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Hospital Records (Address) M.T.H.

15 MAY 27 1921 ROBERT P. LAMASE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1921

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1921, to May 25, 1921, that I last saw him alive on May 24, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. J. Cigrey, M. D.

5-25-21, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashbury Cemetery.	May 27 1921
20 UNDERTAKER	ADDRESS
Milton Davis	413 N. Eden St

CAUSE OF DEATH in plain terms. So worded as to be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54072

CERTIFICATE OF DEATH.

9 REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Pilmor ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Grace Hall

(a) RESIDENCE. No. 1225 No. Pilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? 9 yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Eugene Hall

6 DATE OF BIRTH (month, day, and year) July 22nd 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Baltimore~~ (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Dent

11 BIRTHPLACE OF FATHER (city or town) St. Marys County (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Estepp

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co (State or country) Md.

14 Informant Richard Dent

(Address) Annapolis, Md.

15 MAY 27 1921 ROBERT J. KRAUTER Registrar

Medical Examiner's Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20th, 1921, to May 26th, 1921, that I last saw h alive on May 26th, 1921, and that death occurred, on the date stated above, at 8:58 P m.

The CAUSE OF DEATH was as follows:

Diphtheria

.....(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? — no —

What test confirmed diagnosis? Laboratory

(Signed) James Edw. Dell, M. D.

, 19 (Address) 1234 No. Pilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 27 1921
20 UNDERTAKER	ADDRESS
Edw. Ruggold	1463 Carey

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Do not use abbreviations or technical terms. Omit names of diseases not fatal in themselves, except when they are complications. Do not report symptoms. Do not report conditions which did not contribute to the cause of death. Do not report the mode of dying, such as heart failure, asphyxia, etc. Do not report the cause of a cause. Do not report the cause of a contributory cause. Do not report the cause of a secondary cause. Do not report the cause of a tertiary cause. Do not report the cause of a quaternary cause. Do not report the cause of a quinary cause. Do not report the cause of a senary cause. Do not report the cause of a septenary cause. Do not report the cause of a octonary cause. Do not report the cause of a nonary cause. Do not report the cause of a denary cause. Do not report the cause of a undenary cause. Do not report the cause of a duodenary cause. Do not report the cause of a tredenary cause. Do not report the cause of a quattuordenary cause. Do not report the cause of a quindenary cause. Do not report the cause of a sexdenary cause. Do not report the cause of a septendenary cause. Do not report the cause of a octodenary cause. Do not report the cause of a novendenary cause. Do not report the cause of a vigenary cause. Do not report the cause of a unvigenary cause. Do not report the cause of a duovigenary cause. Do not report the cause of a trevigenary cause. Do not report the cause of a quattuorvigenary cause. Do not report the cause of a quinvigenary cause. Do not report the cause of a sexvigenary cause. Do not report the cause of a septenvigenary cause. Do not report the cause of a octovigenary cause. Do not report the cause of a novenvigenary cause. Do not report the cause of a trigenary cause. Do not report the cause of a untrigenary cause. Do not report the cause of a duotrigenary cause. Do not report the cause of a tretrigenary cause. Do not report the cause of a quattuortrigenary cause. Do not report the cause of a quintrigenary cause. Do not report the cause of a sextrigenary cause. Do not report the cause of a septentrigenary cause. Do not report the cause of a octotrigenary cause. Do not report the cause of a noventrigenary cause. Do not report the cause of a quadragenary cause. Do not report the cause of a unquadragenary cause. Do not report the cause of a duoquadragenary cause. Do not report the cause of a trequadragenary cause. Do not report the cause of a quattuorquadragenary cause. Do not report the cause of a quinquadragenary cause. Do not report the cause of a sexquadragenary cause. Do not report the cause of a septenquadragenary cause. Do not report the cause of a octoquadragenary cause. Do not report the cause of a novenquadragenary cause. Do not report the cause of a quinquagenary cause. Do not report the cause of a unquinquagenary cause. Do not report the cause of a duoquinquagenary cause. Do not report the cause of a trequinquagenary cause. Do not report the cause of a quattuorquinquagenary cause. Do not report the cause of a quinquinquagenary cause. Do not report the cause of a sexquinquagenary cause. Do not report the cause of a septenquinquagenary cause. Do not report the cause of a octoquinquagenary cause. Do not report the cause of a novenquinquagenary cause. Do not report the cause of a sexagenary cause. Do not report the cause of a unsexagenary cause. Do not report the cause of a duosexagenary cause. Do not report the cause of a tresexagenary cause. Do not report the cause of a quattuorsexagenary cause. Do not report the cause of a quinsexagenary cause. Do not report the cause of a sexsexagenary cause. Do not report the cause of a septensexagenary cause. Do not report the cause of a octosexagenary cause. Do not report the cause of a novensexagenary cause. Do not report the cause of a septuagenary cause. Do not report the cause of a unseptuagenary cause. Do not report the cause of a duoseptuagenary cause. Do not report the cause of a treseptuagenary cause. Do not report the cause of a quattuorseptuagenary cause. Do not report the cause of a quinseptuagenary cause. Do not report the cause of a sexseptuagenary cause. Do not report the cause of a septenseptuagenary cause. Do not report the cause of a octoseptuagenary cause. Do not report the cause of a novenseptuagenary cause. Do not report the cause of a octogenary cause. Do not report the cause of a unoctogenary cause. Do not report the cause of a duooctogenary cause. Do not report the cause of a treoctogenary cause. Do not report the cause of a quattuoroctogenary cause. Do not report the cause of a quinoctogenary cause. Do not report the cause of a sexoctogenary cause. Do not report the cause of a septenoctogenary cause. Do not report the cause of a octooctogenary cause. Do not report the cause of a novenoctogenary cause. Do not report the cause of a nonagenary cause. Do not report the cause of a unnonagenary cause. Do not report the cause of a duononagenary cause. Do not report the cause of a trenonagenary cause. Do not report the cause of a quattuornonagenary cause. Do not report the cause of a quinnonagenary cause. Do not report the cause of a sexnonagenary cause. Do not report the cause of a septennonagenary cause. Do not report the cause of a octononagenary cause. Do not report the cause of a novennonagenary cause. Do not report the cause of a centenary cause. Do not report the cause of a uncentenary cause. Do not report the cause of a duocentenary cause. Do not report the cause of a trecentenary cause. Do not report the cause of a quattuorcentenary cause. Do not report the cause of a quincentenary cause. Do not report the cause of a sexcentenary cause. Do not report the cause of a septencentenary cause. Do not report the cause of a octocentenary cause. Do not report the cause of a novencentenary cause. Do not report the cause of a millenary cause. Do not report the cause of a unmillenary cause. Do not report the cause of a duomillenary cause. Do not report the cause of a tremillenary cause. Do not report the cause of a quattuormillenary cause. Do not report the cause of a quinmillenary cause. Do not report the cause of a sexmillenary cause. Do not report the cause of a septenmillenary cause. Do not report the cause of a octomillenary cause. Do not report the cause of a novenmillenary cause. Do not report the cause of a decamillenary cause. Do not report the cause of a undecamillenary cause. Do not report the cause of a duodecamillenary cause. Do not report the cause of a tredecamillenary cause. Do not report the cause of a quattuordecamillenary cause. Do not report the cause of a quindecamillenary cause. Do not report the cause of a sexdecamillenary cause. Do not report the cause of a septendecamillenary cause. Do not report the cause of a octodecamillenary cause. Do not report the cause of a novendecamillenary cause. Do not report the cause of a vigenamillenary cause. Do not report the cause of a unvigenamillenary cause. Do not report the cause of a duovigenamillenary cause. Do not report the cause of a trevigenamillenary cause. Do not report the cause of a quattuorvigenamillenary cause. Do not report the cause of a quinvigenamillenary cause. Do not report the cause of a sexvigenamillenary cause. Do not report the cause of a septenvigenamillenary cause. Do not report the cause of a octovigenamillenary cause. Do not report the cause of a novenvigenamillenary cause. Do not report the cause of a trigenamillenary cause. Do not report the cause of a untrigenamillenary cause. Do not report the cause of a duotrigenamillenary cause. Do not report the cause of a tretrigenamillenary cause. Do not report the cause of a quattuortrigenamillenary cause. Do not report the cause of a quintrigenamillenary cause. Do not report the cause of a sextrigenamillenary cause. Do not report the cause of a septentrigenamillenary cause. Do not report the cause of a octotrigenamillenary cause. Do not report the cause of a noventrigenamillenary cause. Do not report the cause of a quadragenamillenary cause. Do not report the cause of a unquadragenamillenary cause. Do not report the cause of a duoquadragenamillenary cause. Do not report the cause of a trequadragenamillenary cause. Do not report the cause of a quattuorquadragenamillenary cause. Do not report the cause of a quinquadragenamillenary cause. Do not report the cause of a sexquadragenamillenary cause. Do not report the cause of a septenquadragenamillenary cause. Do not report the cause of a octoquadragenamillenary cause. Do not report the cause of a novenquadragenamillenary cause. Do not report the cause of a quinquagenamillenary cause. Do not report the cause of a unquinquagenamillenary cause. Do not report the cause of a duoquinquagenamillenary cause. Do not report the cause of a trequinquagenamillenary cause. Do not report the cause of a quattuorquinquagenamillenary cause. Do not report the cause of a quinquinquagenamillenary cause. Do not report the cause of a sexquinquagenamillenary cause. Do not report the cause of a septenquinquagenamillenary cause. Do not report the cause of a octoquinquagenamillenary cause. Do not report the cause of a novenquinquagenamillenary cause. Do not report the cause of a sexagenamillenary cause. Do not report the cause of a unsexagenamillenary cause. Do not report the cause of a duosexagenamillenary cause. Do not report the cause of a tresexagenamillenary cause. Do not report the cause of a quattuorsexagenamillenary cause. Do not report the cause of a quinsexagenamillenary cause. Do not report the cause of a sexsexagenamillenary cause. Do not report the cause of a septensexagenamillenary cause. Do not report the cause of a octosexagenamillenary cause. Do not report the cause of a novensexagenamillenary cause. Do not report the cause of a septuagenamillenary cause. Do not report the cause of a unseptuagenamillenary cause. Do not report the cause of a duoseptuagenamillenary cause. Do not report the cause of a treseptuagenamillenary cause. Do not report the cause of a quattuorseptuagenamillenary cause. Do not report the cause of a quinseptuagenamillenary cause. Do not report the cause of a sexseptuagenamillenary cause. Do not report the cause of a septenseptuagenamillenary cause. Do not report the cause of a octoseptuagenamillenary cause. Do not report the cause of a novenseptuagenamillenary cause. Do not report the cause of a octogenamillenary cause. Do not report the cause of a unoctogenamillenary cause. Do not report the cause of a duooctogenamillenary cause. Do not report the cause of a treoctogenamillenary cause. 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Do not report the cause of a quattuordecamillenamillenamillenamillenamillenary cause. Do not report the cause of a quindecamillenamillenamillenamillenamillenary cause. Do not report the cause of a sexdecamillenamillenamillenamillenamillenary cause. Do not report the cause of a septendecamillenamillenamillenamillenamillenary cause. Do not report the cause of a octodecamillenamillenamillenamillenamillenary cause. Do not report the cause of a novendecamillenamillenamillenamillenamillenary cause. Do not report the cause of a vigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a unvigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a duovigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a trevigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a quattuorvigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a quinvigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a sexvigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a septenvigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a octovigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a novenvigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a trigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a untrigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a duotrigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a tretrigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a quattuortrigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a quintrigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a sextrigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a septentrigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a octotrigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a noventrigenamillenamillenamillenamillenamillenary cause. Do not report the cause of a quadragenamillenamillenamillenamillenamillenary cause. Do not report the cause of a unquadragenamillenamillenamillenamillenamillenary cause. Do not report the cause of a duoquadragenamillenamillenamillenamillenamillenary cause. Do not report the cause of a trequadragenamillenamillenamillenamillenamillenary cause. Do not report the cause of a quattuorquadragenamillenamillenam

Spec.—8-24-14—M. & T.—2000 Bks.

D54073

HEALTH DEPARTMENT—CITY OF BALTIMORE

54 D 54073

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1027 W. Lexington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Berry

(Residence in Baltimore: No. 1027 W. Lexington St.; 20 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, ..., 1901
(Month) (Day) (Year)

7-AGE, 20 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): Balto.

PARENTS.

10-NAME OF FATHER: Wilson Berry

11-BIRTHPLACE OF FATHER (State or Country): md

12-MAIDEN NAME OF MOTHER: Susan Torney

13-BIRTHPLACE OF MOTHER (State or Country): md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan Berry

(Address) 1027 W Lexington

15-

Filed MAY 27 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH must be plainly and fully stated, giving the primary cause, secondary or contributory cause, and the duration of each. Indefinite terms, such as "Debility," "Old Age," "Cancer," "Consumption," "Paralysis," "Convulsions," "Fever," "Inflammation," "Dropsy," "Tumor," "Abscess," "Ulcer," "Child-bed," "Fits," "Premature Birth," "Stillborn," "Still-born," "Lung Fever," "Bronchitis," "Pneumonia," "Heart Disease," "Kidney Disease," "Liver Disease," "Stomach Disease," "Bowel Disease," "Blood Disease," "Brain Disease," "Womb Disease," "Skin Disease," "Bone Disease," "Joint Disease," "Gland Disease," "Eye Disease," "Ear Disease," "Throat Disease," "Nose Disease," "Lung Disease

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54074

CERTIFICATE OF DEATH.

55 D 54074

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stratford St. John Buchman

(a) RESIDENCE. No. Washington Apts ST.. WARD. St Louis Mo

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 19 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineering 088

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Merrill & Chapman

9 BIRTHPLACE (city or town) (State or country) Lyman Iowa

PARENTS

10 NAME OF FATHER Rev. F. J. Buchman

11 BIRTHPLACE OF FATHER (city or town) Prescott (State or country) Wis

12 MAIDEN NAME OF MOTHER Martha Klaeman

13 BIRTHPLACE OF MOTHER (city or town) Hazleton (State or country) Pa

14 Informant Adrian L Buchman

(Address) 301 Pierce Bldg St Louis Mo

15 Filed MAY 27 1921 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to May 26, 1921, that I last saw him alive on May 26, 1921, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) 36 hrs mos. ds.

18 Where was disease contracted if not at place of death? Dont Know.

Did an operation precede death? No Date of V

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) W. F. Martin, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Louis Mo	May 27 1921
20 UNDERTAKER	ADDRESS
Wm Pickney Sons	Mt Ch & Pa

CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificates.

Lupus

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54075

CERTIFICATE OF DEATH.

99

D 54075

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 S Fulton Av ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lupus

(a) RESIDENCE. No. 109 S Fulton Av ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27 1857 ~~1859~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in whirh employed (or employer): ——

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Amos L Gorsuch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Jane Ballenger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Charlotte (Address) 109 S Fulton Av

15 FILED: MAY 27 1921 ROBERT J. LAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1921

17

I HEREBY CERTIFY, That I attended deceased from July 3, 1916, to May 25, 1921, that I last saw her alive on May 25, 1921, and that death occurred, on the date stated above at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(durntion) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis, Cardiac Hypertrophy (duration) 2 yrs. 10 mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James H Cotzenberger M. D.

5/27, 1921 (Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 27/1921
20 UNDERTAKER	ADDRESS
C. A McCormick	1931 W Fayette

CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificates.

D 54076

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54076

CERTIFICATE OF DEATH.

159

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1028 Falls Road ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob H. Fisher

(Residence in Baltimore: No. 1028 Falls Road

S. 36 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, March 14, 1858.
(Month) (Day) (Year)

7-AGE, 63 yrs. 2 mos. 11 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): O'S

9-BIRTHPLACE. (State or Country). York Co. Pa.

PARENTS.

10-NAME OF FATHER. Jacob Fisher

11-BIRTHPLACE OF FATHER. (State or Country). York Co. Pa.

12-MAIDEN NAME OF MOTHER. Lydia Stonesifer

13-BIRTHPLACE OF MOTHER. (State or Country). York Co. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Fisher

(Address) 1028 Falls Road

15- MAY 27 1921 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 25, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun shot wound
Through head
Suicide
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....
(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Lincoln Morrison M. D.
(Coroner)
May 26, 1921 (Address) 3632 Rolandve

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL. New Freedom, Pa. DATE OF BURIAL. May 28, 1921

20-UNDERTAKER. Horace H. Burgee ADDRESS 3631 Falls Rd

N. B.—Every item of information must be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54077

CERTIFICATE OF DEATH.

79 D 54077

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 819 E. 22nd St. (ST.:) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry H. Ricks

(a) RESIDENCE. NO. 819 E. 22nd St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. - mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie M. Ricks

6 DATE OF BIRTH (month, day, and year) May 17-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Union Ships Bldg. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John A. Ricks

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Lottie H. Cornell

13 BIRTHPLACE OF MOTHER (city or town) Savage (State or country) Md.

14 Informant Mrs. Marie M. Ricks (Address) 819 E. 22nd St.

15 Filed MAY 27 1921 19 ROGER J. KRAUTER Registrar [illegible] Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1921, to May 26 1921, that I last saw h.. alive on May 25 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation & Sarcoma

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Decided mitral murmur

(Signed) P. J. Carman M. D.

5-27-1921 (Address) 1212 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden)

DATE OF BURIAL May 30 1921

UNDERTAKER Horace H. Burgee

ADDRESS 3631 Falls Rd.

CAUSE OF DEATH in plain terms, so that a layman can understand it. See instructions on back of certificates. TION is very important.

D 54078 HEALTH DEPARTMENT—CITY OF BALTIMORE

120 D 54078

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 39th & O'Donnell Street ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Fisher

(Residence in Baltimore: No. 39th & O'Donnell Street St.: 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April 17 (Month) (Day) 1867, 1 (Year)

7-AGE,	If LESS than 1 day,
54 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Structural Iron
(b) General nature of industry, business, or establishment in which employed (or employer): worker 079

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Leanord Fisher

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Jesse Shaffer

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Moran

(Address) 3000 E. Baltimore St.

15- MAY 27 1921 Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Grau Koch M. D.
(Coroner.)
5/27/21, 191... (Address) 1800 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Hampden — DATE OF BURIAL, 5-27-, 1921

20-UNDERTAKER J J Moran — ADDRESS 3000 E Balto St.

S. B.—Every item of DEATH in plain terms, so that it may be understood. CAUSE OF DEATH important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54079

D 54079

CERTIFICATE OF DEATH.

X .64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2211 Chelsea Terrace ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Culpepper Brown.

(a) RESIDENCE. NO. 2211 Chelsea Terrace ST., WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olivia C. Brown.

6 DATE OF BIRTH (month, day, and year) May 5th, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	----	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot (Retired) 086

(b) General nature of industry, business, or establishment in which employed (or employer) Steamboat.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Portsmouth Va.

PARENTS

10 NAME OF FATHER James Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portsmouth Va.

12 MAIDEN NAME OF MOTHER Olivia C. Readon.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portsmouth Va.

14 Informant J.B. Brown.

(Address) 2211 Chelsea Terrace.

15 Filed MAY 27 1921 ROBERT J. (illegible) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17

I HEREBY CERTIFY, That I attended deceased from May 18, 1921, to May 26, 1921, that I last saw him alive on May 26, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) C. M. Culpepper M. D.

May 27 1921 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Portsmouth Va.	May 27, 1921
20 UNDERTAKER	ADDRESS
Bertram W. Gore	1723 W Lafayette Ave.

CAUSE OF DEATH in plain terms, so that it may be classified. Do not use abbreviations or symptoms on back of certificates. See instructions on back. TION is very important.

Sp[illegible]-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54080

D 54080

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3219 Dillon ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman A. Schmeiser

(a) RESIDENCE. NO. 3219 Dillon ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 7-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Albert H. Schmeiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Louisa Bauersfeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Albert H. Schmeiser
(Address) 3219 Dillon St.

15 MAY 27 1921 ROBERT J. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 26, 1921, that I last saw him alive on May 26, 1921, and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Premature Birth 7 mo.

Uter-Gest (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. McAvoy, M. D.

6/27. 1921 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	May 28 1921
20 UNDERTAKER	ADDRESS
Zickler & Zickler	1739 E. Eager

CAUSE OF DEATH must be given. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54081

CERTIFICATE OF DEATH.

151 D 54081

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fred Keil. Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mitzel

(a) RESIDENCE. NO. 1703 N. Bethel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 25 21

7 AGE: Years Months Days: 1

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer 000

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Charles Mitzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hedwesville W. Va.

12 MAIDEN NAME OF MOTHER: Nellie Reuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Chas Mitzel
(Address) 1703 N Bethel

15 Filed MAY 27 1921 19 ROBERT J. KRAUTER Registrar By Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25 1921, to May 26 1921, that I last saw h[illegible] alive on May 26 1921, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Fred B. Smale M. D.

May 26 1921 (Address) Fred. Keil. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: May 27 1921

20 UNDERTAKER: Geo Kinner — ADDRESS: 1422 N Mts

CAUSE OF DEATH in plain terms. Abbreviations must not be used. Medical certificate on back of certificates. ATTENTION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54082

CERTIFICATE OF DEATH.

40 D 54082

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 N Fulton ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary E S Johnson

(a) RESIDENCE. NO. 810 N Fulton ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edward A Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home 037
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Black Rock
(State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Thomas M Scott

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Shual

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country)

14 Informant Ed Johnson
(Address) 810 N Fulton ave

15 Filed MAY 27 1921 ROBERT E KRAUTER Registrar
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to May 26, 1921, that I last saw h.. alive on May 24, 1921, and that death occurred, on the date stated above, at 12:10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 9 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

May 27, 1921 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Black Rock Balto Co Md	May 29 1921
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Forest Rd

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54083

CERTIFICATE OF DEATH.

91 D 54083
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Hilmer ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Theodore Clay

(Residence in Baltimore: No. 1032 Hilmer St.; 4/12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	C	Single

6-DATE OF BIRTH, Aug (Month) 18 (Day), 1918 (Year)

7-AGE, 2 yrs. 8 mos. 7 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas Clay

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Bertha Chase

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Clay

(Address) 1032 Hilmer

15- MAY 27 1921 ROBERT J. REUTER
Filed....., 191.....
Burial Permit No. 61063

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 25 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 24 1921, to May 24 1921, that I saw h[illegible] alive on May 24 1921, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Asthma

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William E Burslem M. D.

May 25, 1921. (Address) 162 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	May 28th, 1921

20-UNDERTAKER Joseph A Farrell | ADDRESS 2319 Division

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54084

CERTIFICATE OF DEATH.

100

D 54084

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2139 W. North Ave (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Clifton McDermott

(a) RESIDENCE. No. 2139 W. North Ave St. Ward. Lifetime

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1913

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	7	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Matthew J. McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Annie Schanze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Geo. E. Shannon 700 Fulton Ave

15 Filed MAY 27 1921 19 ROBERT E. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1921, to May 26, 1921, that I last saw h.. alive on May 26, 1921, and that death occurred, on the date stated above, at 9.25 p. m.

The CAUSE OF DEATH* was as follows:

Tonsilitis Cerebral

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? By Consultation

(Signed) Geo. E. Shannon, M. D.

, 19 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Cathedral May 30 1921

20 UNDERTAKER — ADDRESS

Martin Saher & Sons 1827 W North Ave

CAUSE OF DEATH in plain terms, without abbreviations. Name of contagious disease, if any, must be given. Duration of disease must be stated. Omission to state these facts will delay registration of certificates. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Cuomo

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54085

CERTIFICATE OF DEATH.

D 54085

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3917 E Lombard ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonio Cuomo

(a) RESIDENCE. No. 3917 E. Lombard ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3 1901

7 AGE 20 Years 1 Months 14 Days If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Machine Shop.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Filippo Cuomo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Luisa Pescara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Filippo Cuomo 3917 E. Lombard St.

15 Filed APR 19 1921 19 Registrar

MAY 27 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1921

17

I HEREBY CERTIFY, That I attended deceased from August 20 1920 to April 19 21, that I last saw him alive on April 17 21 and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Maxwell F Mayer M. D.

4/18/21 (Address) 3115 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. DATE OF BURIAL: 4/19/21 19

20 UNDERTAKER: George J. Ruth ADDRESS: 1735 Hanford ave

CAUSE OF DEATH in plain terms, so that a ... TION is very important. See instructions on ... gs on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. North Point Road & Eastern Ave ST.: WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Cuomo

(a) RESIDENCE. NO. 3927 E Lombard St WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3, 1901

7 AGE 20 Years 1 Months 14 Days | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer): Machine Shop
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS
10 NAME OF FATHER: Fellippo Cuomo
11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy
12 MAIDEN NAME OF MOTHER: Lusia Pessicano
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Fellippo Cuomo 3927 E Lombard St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1921

17 I HEREBY CERTIFY, That I attended deceased from August 20 1920 to April 17 1921, that I last saw h[illegible] alive on April 17 1921, and that death occurred, on the date stated above, at 330 m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Tuberculosis

(Signed) Maxwell Magee M.D.
(Address) 3115 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cemetery	April 19 1921

20 UNDERTAKER: George F Ruth ADDRESS 1735 Aisquith

CAUSE OF DEATH in plain terms, so that it may be understood. See back of certificate. TION is very important. See instructions on back.

Spec. 6-9-19—H. P. Co.—1000 Pks.

D 54086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54086

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 N. Fulton ave ST. 16 WARD)

2-FULL NAME Luther M. Longshaw

(a) RESIDENCE. NO. 901 N. Fulton ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	widowed

5a If married, widowed, ~~divorced~~ of ~~husband~~ ~~wife~~ of Annie F. Longshaw

6 DATE OF BIRTH (month, day, and year) July 30-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired 186

(b) General nature of industry, business, or establishment in which employed (or employer) Broker

(c) Name of employer

9 BIRTHPLACE (city or town) Kentucky
(State or country)

PARENTS

10 NAME OF FATHER Wm. Longshaw

11 BIRTHPLACE OF FATHER (city or town) Ky.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) Ky.
(State or country)

14 Informant Marie E. Dar
(Address) 901 N. Fulton ave

15 MAY 27 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17 I HEREBY CERTIFY, That I attended deceased from 14 April, 1920, to 27 May, 1921, that I last saw h im alive on 26 May, 1921, and that death occurred, on the date stated above, at 6.27 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Urinalysis - B.P. &c

(Signed) Horace W. Byers, M. D.

19 (Address) 749 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Everett, Mass	May 29 1921

20 UNDERTAKER John O'Mitchell ADDRESS 1320 W. Fayette &

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54087

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 East 31st ST. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Howard Melville

(a) RESIDENCE. No. 413 East 31st ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Anna Melville

6 DATE OF BIRTH (month, day, and year) Oct 7-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Melville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER ~~unknown~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elza Stephens

14 Informant Anna V. Melville

(Address) 413 E 31st

15 Filed ..... 19..... Robert P. Harrison, Registrar

MAY 27 1921 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be understood by the Registrar. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17

I HEREBY CERTIFY, That I attended deceased from ..... 19 15, to 5/26/21, 19....., that I last saw him alive on 5/20/21, 19....., and that death occurred, on the date stated above, at 1450 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) H W Gadden, M. D.

5/26/21 (Address) 32 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	May 28 1921
20 UNDERTAKER Urban Cook	ADDRESS 504 E Nth

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54088

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54088

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2837 Frederick AVE ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara E Pedrick

(a) RESIDENCE. No. 2837 Frederick Ave ST., ... WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow John J Pedrick

6 DATE OF BIRTH (month, day, and year): June 11 1854

7 AGE: Years 66 Months 11 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs C V Smith 2837 Frederick Ave

15 Filed ..... Robert P. Harrison, Registrar

MAY 27 1921

Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 15. 1921, to May 25. 1921, that I last saw h[illegible] alive on May 25. 1921, and that death occurred, on the date stated above, at 12.45 p m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

Duration 1/ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): C Knockout,

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W Wilson, M. D.

, 19 (Address) 1735 Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemt	May 28 1921

20 UNDERTAKER: Wm Cahill — ADDRESS: 502 E Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54089 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54089

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 Beaumont Ave ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hipsley

(a) RESIDENCE. No. 804 Beaumont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	baby

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25-1921

7 AGE	Years	Months	Days	If LESS than 1 day, 16 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 804 Beaumont Ave Balto-Md.

PARENTS

10 NAME OF FATHER Oscar Hipsley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Mae Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md. Md.

14 Informant Oscar Hipsley
(Address) 804 Beaumont Ave

15 Filed MAY 27 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25th, 1921, to May 26, 1921, that I last saw him alive on May 26, 1921, and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Convulsion

about 5 minutes.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? During foetal life.

Did an operation precede death? No. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm Conrad Bode, M. D.

. 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Prospect Hill Cem	May 27 1921
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson,

CAUSE OF DEATH to be plain, full and specific. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Baby was premature due to condition of mother who is suffering from Cardio Renal trouble.

M. B.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54090 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54090

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 Light ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Deters

(a) RESIDENCE. No. 1131 Light ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth Deters

6 DATE OF BIRTH (month, day, and year) Jan. 28th. 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Alma Mfg Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H Deters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Busch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary Deters
(Address) 4510 Pimlurst ave

15 Filed Robert P. Harrison, Registrar

MAY 27 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1921

17 I HEREBY CERTIFY, That I attended deceased from November, 1919, to May 25th, 1921, that I last saw him alive on May 24th, 1921, and that death occurred, on the date stated above, at 7: A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) C. P. Burton, M. D.

5/25 1921 (Address) 301 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. A.A.C.	5-26th 1921
20 UNDERTAKER	ADDRESS
E and B Harle	115 E West St.

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. Abbreviations must not be used. Information is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

20.54091 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.54091

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 148 Wilkens ST.: 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Bealer

(Residence in Baltimore: No. 148 Wilkens St.: 63 yrs., 4 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, ... Jan (Month) 20 (Day), 1848 (Year)

7-AGE, 63 yrs. 4 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie E. Rush

(Address) 148 Wilkens St.

15-

Filed..... Robert P. Harrison, 191.....

Registrar.

MAY 27 1921 Burial Permit Clerk.

CAUSE OF DEATH must be plainly written. Every question must be answered if possible. Unknown or Cannot be ascertained may be used when necessary, but the certificate is more valuable if every answer is complete. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 26 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 11 1921 to May 26 1921, that I saw her alive on May 25 1921, and that death occurred, on the date stated above, at 4.25 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

Causing right Hemiplegia

Aphasia (Duration) 1 yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Deformans

complicated by Old Pneumonia (Duration) 1 yrs. 11 mos. 2 ds.

(Signed) Henry C. Ort M. D.

May 27, 1921. (Address) 1208 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet Baltimore County | DATE OF BURIAL, May 28th, 1921

20-UNDERTAKER: H. B. Hospelt | ADDRESS: 1236 Fulton Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. [illegible] WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Draos

(a) RESIDENCE. NO. Hallidaysburg Mt Hope Retreat Rd ST., 28 WARD. Hallidaysburg Pa -
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? 29 yrs. 7 mos. 11 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 11th 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	2	11	

8 OCCUPATION OF DECEASED 1st Class Varg- U.S.A.

(a) Trade, profession or particular kind of work Army

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer U. S.

9 BIRTHPLACE (city or town) Hallidaysburg Pa
(State or country)

PARENTS

10 NAME OF FATHER John Draos

11 BIRTHPLACE OF FATHER (city or town) Hollidaysburg Pa
(State or country)

12 MAIDEN NAME OF MOTHER E. C. Pullon

13 BIRTHPLACE OF MOTHER (city or town) Hollidaysburg
(State or country) Pa

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md.

15 MAY 27 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27th 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 - 1920, to May 27th, 1921, that I last saw him alive on May 26th, 1921, and that death occurred, on the date stated above, at 4.10 A. m.

The CAUSE OF DEATH* was as follows:

Paresis - (Specific)

Abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Sub-acute Mania

Over (duration) 0 yrs. 9 mos. 0 ds.

18 Where was disease contracted if not at place of death? Don't know -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 27, 1921 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hollidaysburg Pa	May 31 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

...ns on back of certificates. ...TION is very important. See instructions on

Kennedy ✓

D 54093

Spld 6-8-20 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54093

D [redacted]

CERTIFICATE OF DEATH.

47 D [redacted]

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 Aiken St ST.: 9 WARD)

2-FULL NAME Michael Kennedy

(a) RESIDENCE. No. 2124 Aiken St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 7 years — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 5/30/1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chckd. gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte N. Carolina

PARENTS

10 NAME OF FATHER Michael McKennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlotte, N.C

14 Informant M. E. Kennedy. (Address) 2124 Aiken st.

15 MAY 27 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1921, to May 26, 1921, that I last saw h in alive on May 25, 1921, and that death occurred, on the date stated above, at 10.35A m.

The CAUSE OF DEATH* was as follows:

Endo Carditis

(duration) yrs. 5+ mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter A. Baetjer M. D.

5/26 1921 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 28 1921
20 UNDERTAKER	ADDRESS
George L. Ruth	735 Harford

mation should be carefully supplied, so that it may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54094

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54094

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Druid Hill Ave St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Porter

(a) RESIDENCE. NO. 1108 Druid Hill Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 26-1921

7 AGE	Years	Months	Days	If LESS than 1 day 18 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Lisa Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Ella Johns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Ella Porter — mother

(Address): 1108 Druid Hill Ave

15 Filed ... 19 ... Robert P. [illegible] Registrar

6-28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1921, to May 27, 1921, that I last saw h[illegible] alive on May 27, 1921, and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity
(36 wks. faeter)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Rees, M. D.

6-27 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	May 28 1921

20 UNDERTAKER: Samuel A. Hawley

ADDRESS 518 N. Bradford St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54095 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54095

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 13 Ward)

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius Weil

(Residence in Baltimore: No. 2320 Druid Hill Ave. St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. June 5, 1849. (Month) (Day) (Year)

7-AGE. 72 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Butcher 013
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), France

PARENTS.

10-NAME OF FATHER. Samuel Weil

11-BIRTHPLACE OF FATHER (State or Country). France

12-MAIDEN NAME OF MOTHER .....

13-BIRTHPLACE OF MOTHER (State or Country). France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sandy Rosenheim

(Address) 2536 Madison Ave

15- Robert P. Harrison,

Filed ....., 191..... Registrar.

MAY 28 1921 Burial Permit Signed

CAUSE OF DEATH. important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 9 1921, to May 26 1921, that I saw him alive on May 26 1921, and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Chr. Nephritis

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
Thrombophlebitis (Duration) .....yrs. .....mos. 11 ds.
Uremia

(Signed) Nathan J. Davidson M. D.

5-26-, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, May 29, 1921.

20-UNDERTAKER J. Abrens & Co — ADDRESS 1611 Mad Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54096

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Home For Incurables (Guilford Ave & 31st St) ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Pue Raitt

(a) RESIDENCE. No. Home For Incurables ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If ~~married~~ widowed, ~~or divorced~~
~~HUSBAND~~ of
(or) WIFE of Henry Clay Raitt

6 DATE OF BIRTH (month, day, and year) Aug 5.1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George I. Kennard

11 BIRTHPLACE OF FATHER (city or town) Harford Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Pue

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.
(State or country) Maryland

14 Informant Mary P. Scott (daughter)
(Address) 700 N. Appelton St.

15 Filed MAY 28 1921, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1921, to May 27, 1921, that I last saw h~~im~~ alive on May 26, 1921, and that death occurred, on the date stated above, at 5:10 A m.

The CAUSE OF DEATH* was as follows:

Coma Senilis - (Old Age)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Fracture Neck of Femur

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? — (Home)

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms etc

(Signed) [illegible], M. D.

, 19 (Address) 1800 N Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 28 1921
20 UNDERTAKER	ADDRESS
H.E. Hughes	424 N. Broadway

CAUSE OF DEATH to be given on back of certificates. ATTENTION is very important. See instructions on back.

D 54097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54097

CERTIFICATE OF DEATH.

x 64

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1024 Maldise ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace a Cook

(Residence in Baltimore: No. 1024 Maldise st- St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ... Jan (Month) 14 (Day), 1899 (Year)

7-AGE, 21 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 031

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Robert Charles

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Cook

(Address) 1024 Maldise ST

15-

Filed MAY 28 1921, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) 26 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, ~~autopsy~~ or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

a few hours
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

5-27-, 1921. (Address) 117 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Petersburg Va.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	May 28 1921
20-UNDERTAKER William Cook	ADDRESS 502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54098 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54098

35

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns. Hopkins Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irma Wolfe

(a) RESIDENCE. NO. 400 Pinkney Place ~~West~~ St. City WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 5 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1904.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier 509

(b) General nature of industry, business, or establishment in which employed (or employer) Department Store

(c) Name of employer Hutzler Bros.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Fe. Finkelstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns. Hopkins Hospital. Records

15 Filed . 19 Registrar

2 8 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17

I HEREBY CERTIFY, That I attended deceased from Feb 25- . 1921 . to May 26- . 1921 .

that I last saw her alive on May 26- . 1921 .

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Generalized tuberculosis.

Renal tuberculosis bilateral

Urine much of time (duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto Md.

Did an operation precede death? yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Tbc bacilli in urine.

(Signed) H. H. Thomas, M. D.

5 27 . 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 31 1921
20 UNDERTAKER	ADDRESS
Harry J. Witzke	1531 W. Fayette St

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54099 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54099

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Holbrook St.: 9 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph V. Miskelly

(a) RESIDENCE. No. 1414 Holbrook St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Elizabeth S. Miskelly

6 DATE OF BIRTH (month, day, and year) Sept. 23 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass finisher

(b) General nature of industry, business, or establishment in which employed (or employer) D10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Joseph V. Miskelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma F. Chester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Elizabeth S. Miskelly

(Address) 1414 Holbrook St

15 Filed ..... Robert P. Harrison, Registrar

MAY 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to May 27, 1921, that I last saw h.. alive on May 27, 1921, and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arteriosclerosis

Hypotension

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemmorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Microscopic

(Signed) J. H. Thomas, M. D.

May 28 1921 (Address) 1228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 30 1921
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1301 E Eager

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHIER STATEMENTS BY PHYSICIAN.

Not Luetic. High Blood pressure Conduct caused hemorrhage.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54100

CERTIFICATE OF DEATH.

4 X 92

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.; 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethyl C. Gardner

(a) RESIDENCE. NO. Elliott City ST.. WARD. Elliott City Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jno. Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hunton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records

(Address) Robert P. Harrison,

15 MAY 28 1921 19 Burial Permit Clerk. Registrar

CAUSE OF DEATH to plain terms, avoiding use of technical terms. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1921, to May 26, 1921, that I last saw h[illegible] alive on May 26, 1921, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis L. Adams, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Gilboa Cem.	May 29 '21
20 UNDERTAKER	ADDRESS
Easton Sons	Elliott City

Spec. 6-9-19-M. P. Co.—1000 Bks.

148 D 54101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 D 54101

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna McCary

(a) RESIDENCE. No. 933 Rutland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6-1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Sam McCary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Queen Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) John Hopkins Hospital Record

15 Filed MAY 28 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25 1921, to May 27 1921, that I last saw her alive on May 27, 1921, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Norton Caspars, M. D.

5-28-21 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	May 28 1921
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Ashland Ave

CAUSE OF DEATH in plain terms, as directed on back of certificates. See instructions on back TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54102

CERTIFICATE OF DEATH.

150

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 W. Cross ST.: 21 WARD)

2-FULL NAME Charles E. O'Neal

(a) RESIDENCE. No. 1026 W. Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
				5 hrs. 30 min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER William W. O'Neal

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Boyle

13 BIRTHPLACE OF MOTHER (city or town) Montgomery Co
(State or country)

14 Informant William W O Neal
(Address) 1026 W. Cross st.

15 Filed MAY 28 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1921, to May 27, 1921.

that I last saw him alive on May 27, 1921.

and that death occurred, on the date stated above, at 11 PM m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J M Dellet, M. D.

1921 (Address) 621 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 28 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1011 S Paca st

CAUSE OF DEATH to be filled in plainly and completely. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54103

D 54103

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Carney

(a) RESIDENCE. No. 102 S. Eutaw St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston, Massachusetts.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed MAY 28 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1921, to May 25, 1921, that I last saw him alive on May 25, 1921, and that death occurred, on the date stated above, at 9:50 A. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis.
Cerebral thrombosis. (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of pharynx (duration) 1 ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) R. H. Herman M. D.

5/25/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL: MAY 28 1921

20 UNDERTAKER: Commissioner Health. ADDRESS

FOR WM. F. WOODALL

CAUSE OF DEATH must be filled in plainly. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54104

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry

(a) RESIDENCE. No. 353 N. High St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Henry Baynard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed MAY 28 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 26, 1921, that I last saw h. im alive on May 26 1921, and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Anuerisum of aorta.

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No especial test.

(Signed) W. B. Eeoman, M. D.

5-26-1921 Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

UNIVERSITY OF MARYLAND MAY 28 1921 19

20 UNDERTAKER — ADDRESS

Commissioner Health,

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54105

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 - D 54105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3901 Lloyd Ave St.: 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas William Raab

(a) RESIDENCE. No. 3901 Lloyd Ave St., 28 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 10 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) May-17-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry S. Raab

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Penna

12 MAIDEN NAME OF MOTHER Elizabeth M. Eastwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Camden New Jersey

14 Informant Henry S. Raab (Father)

(Address) 3901 Lloyd Ave

15 Filed Robert P. Harrison, Registrar

MAY 28 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27 1921

17 I HEREBY CERTIFY, That I attended deceased from 5/24, 1921, to 5/27, 1921, that I last saw him alive on 5/26, 1921, and that death occurred, on the date stated above, at noon m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Bronchial,

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Shock, Prematur

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Henry Carroll M. D.

, 19 (Address) 3402 Groveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Darby, Delaware Co. Pa	May 28 1921

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM C. MOWEN, Secretary)

ADDRESS

CAUSE OF DEATH in plain words. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54106

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54106

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 Oxford St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sampson Butler

(a) RESIDENCE. No. 525 Oxford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Mildred Butler
(Address) 525 Oxford St

15 Filed 19 Robert P. Harrison, Registrar

MAY 28 1921

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27/ 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1921, to May 27, 1921, that I last saw h[illegible] alive on May 27, 1921, and that death occurred, on the date stated above, at 1 5/11 a.m.

The CAUSE OF DEATH* was as follows:

mitral Regurgitation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy.

(Signed) Edward J. Wheatley, M. D.

5/27/1921 (Address) 1230 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Hill Cem. Va Northumberland Co	May 28 21
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Monument

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54107

CERTIFICATE OF DEATH.

28 D 54107

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Jeter

(a) RESIDENCE. No. 1514 Vine st. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Jeter

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Tilman Dyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Isabel ??

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

15 Filed MAY 28 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1921, to May 24, 1921, that I last saw her alive on May 24, 1921, and that death occurred, on the date stated above, at 10.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) L. S. Fahndrich, M. D.

5-25-21, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: MAY 28 19

20 UNDERTAKER: Commissioner Health,

ADDRESS

CAUSE OF DEATH. Please write plainly. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54108

CERTIFICATE OF DEATH.

28 D 54108

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 2 WARD)

2-FULL NAME Oscar Suovonan

(a) RESIDENCE. NO. 1710 Thames st. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10 NAME OF FATHER Oscar Suovonan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland

12 MAIDEN NAME OF MOTHER Sophia Ericsson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Finland

14 Informant Hospital Records (Address) M. T. H.

15 Filed MAY 28 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1921, to May 24, 1921, that I last saw him alive on May 24, 1921, and that death occurred, on the date stated above, at 7.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous broncho pneumonia (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Wm. S. Fahndrich, M. D.

5-25-21. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND. DATE OF BURIAL MAY 28 1921

20 UNDERTAKER Commissioner Health. ADDRESS

Per. Wm. F. WOODALL

CAUSE OF DEATH must be filled in plainly. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54109

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 54109
REGISTERED No. C

CITY OF BALTIMORE (No. 2104 Fairmount St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Paulsen

(Residence in Baltimore: No. 2104 Fairmount St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1871 (Year)

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levis

(Address) 1411 E Baltimore St

15- Filed MAY 29 1931, 191..... ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 27 (Day), 1931 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows

Cerebral Hemorrhage

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Hyman Insley M. D.
5-27-31, 191.. (Address) 4 E. Lexington (Coroner.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lehrenfreindsday Co — DATE OF BURIAL, 5-29-31, 19..

20-UNDERTAKER Jack Levis — ADDRESS 1411 E Baltimore

N.B.—Burial may not be proceeded with until this certificate is filed. CAUSE OF DEATH in plain terms, so that if may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54110

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54110

CERTIFICATE OF DEATH.

REGISTERED NO. 109-091

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No.) North Broadway (ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Moses Levy

(a) RESIDENCE. NO. 1436 E. Baltimore St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Levy

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Planner

(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1411 E Balto St

15 Filed MAY 29 1921 Burial Permit Issued Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1921, to May 27, 1921, that I last saw him alive on May 27, 1921, and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows: over

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 23/1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Noble M. D.

19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrer Herring Run — DATE OF BURIAL 5/29, 1921

20 UNDERTAKER Jack Levis — ADDRESS 1411 E Balto St

CAUSE OF DEATH to be plainly written in ink. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for hernia.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54111

CERTIFICATE OF DEATH.

30 D 54111

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 Mulliken ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Wynn.

(a) RESIDENCE. No. 1509 Mulliken ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 13-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Bldg Contractors

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER Jesse Wynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Ferguson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant (Address) Jesse Wynn 1509 Mulliken

15 Filed MAY 29 1921 ROBERT I. CRAUTER Registrar

Burial Permit Issued

CAUSE OF DEATH to be filled in plainly and completely. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 25 1921, to May 26, 1921, that I last saw him alive on May 26, 1921, and that death occurred, on the date stated above, at 11.45 Am.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis (duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of V

Was there an autopsy? no

What test confirmed diagnosis? Regular.

(Signed) F. C. Link M. D.

May 29-1921 (Address) 1313 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Arbury Cemetery May 29 1921

20 UNDERTAKER — ADDRESS

Milton - Davis 413 N Eden St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54112

CERTIFICATE OF DEATH.

8-091

D 54112

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1644 N. Gilmore ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Minnick

(a) RESIDENCE. No. 1644 N. Gilmore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Minnick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Na

12 MAIDEN NAME OF MOTHER Mary Hums

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Na

14 Informant Mary Minnick
(Address) 1644 N. Gilmore ST

15 Filed MAY 29 1921 Robert J. Leuter Registrar

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to May 28, 1921, that I last saw h[illegible] alive on May 28, 1921, and that death occurred, on the date stated above, at 11-50 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.

5-28. 1921 (Address) 120½ Paisquick St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Interment — DATE OF BURIAL May 29 1921

20 UNDERTAKER W. Marvin Rouzer — ADDRESS 2258 N. Milton Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54113

CERTIFICATE OF DEATH.

120 D 54113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 11 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Boyde

(a) RESIDENCE. No. 1121 McCulloh ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER ~~Hamit~~ Carrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maria Robbins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Daniel Easton
(Address) 916 Pine

15 Filed MAY 29 1921 19 ROBERT J. [illegible] Registrar
Burial Permit Issued

CAUSE OF DEATH IN PLAIN TERMS, without abbreviations. Do not use terms of disease, but state the actual cause of death. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17

I HEREBY CERTIFY, That I attended deceased from May 26, 1921, to May 27, 1921 that I last saw her alive on May 27, 1921, and that death occurred, on the date stated above, at 8 a. m. The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. C. Manning, M. D.

, 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 30 1921
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pine St

UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic nephritis.
No further history

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54114

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 137 D 54114

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Meyers

(a) RESIDENCE. No. 1116 Bolton ST., WARD. Monkton Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced (or) WIFE of Louis Meyers.

6 DATE OF BIRTH (month, day, and year) Nov. 21-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wrk

(b) General nature of industry, business, or establishment in which employed (or employer) " " 037

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland.

PARENTS

10 NAME OF FATHER George Smith

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Clara Kelly

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Maryland.

14 Informant Husband (Louis Meyers.) (Address) 1116 Bolton St.

15 Filed MAY 29 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 13 Th. 1921, to May 27, 1921, that I last saw her alive on May 27 Th, 1921, and that death occurred, on the date stated above, at 11:05 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 21 1921

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

May 27 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Monkton, Balto Co) Md	May 29 1921
20 UNDERTAKER Horace H. Burgee	ADDRESS 363 Falls Rd

CAUSE OF DEATH in plain words. [illegible] on back of certificate. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54115 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 54115

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Texas Beach Lane near Reisterstown Rd. ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mattie Allen

(a) RESIDENCE. No Reisterstown Rd. north of Glen av. ST.; WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wht	Married

5a If married, ~~widowed, or divorced~~ HUSBAND) of (or) WIFE of Joshua P. Allen

6 DATE OF BIRTH (month, day, and year) Oct 12th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Stock Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Charles E. Allen (Address) Reist Rd near Glen Av

15 Filed MAY 29 1921 19 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Oct 13th 18, to May 28, 21, that I last saw h alive on May 27, 21, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows: Progressive Bigul Paralysis following Flu

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Grad. Marasmus & diabetes

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) C. A. Smith, M. D.

May 28 19 21 (Address) 1625 N. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL May 31 1921

20 UNDERTAKER Horace H. Burgee — ADDRESS 363 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be readily understood. TION is very important. See instructions on back of certificates.

D 54116

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

8-091 D 54116

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1612 Vincent St. St.: 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Virgia Williams

(Residence in Baltimore: No. 1612 Vincent St St.: yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: ~~White~~ Colord

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Jan 20 (Month) (Day), 1921 (Year)

7 AGE: ..... yrs. 4 mos. ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Harvey Williams

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lyza Baley

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harvey Williams

(Address) 1612 N Vincent St

15 Died MAY 29 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 27 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1921, to May 27 1921, that I saw her alive on May 27, 1921, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia
and Whooping Cough

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) Bronchs Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) W. S. Welch M. D.

May 28/21, 191 (Address) 2220 Harrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn DATE OF BURIAL: MAY 29 1921, 191

20 UNDERTAKER: JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. Exact statement of facts must be given. Be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54117

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 54117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Wright

(a) RESIDENCE. No. 1341 Mosher St., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Fifs yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of 1898

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Wright

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Bertha Carter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Hospital Records
(Address) New City Hospital.

15 Filed MAY 29 1921 ROBERT J. BRAUTHA Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1921, to May 26, 1921, that I last saw her alive on May 26, 1921, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis (bacterial)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ulyocardial insufficiency (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V B Heyman M. D.

5-27-21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

T M D Auburn Cem. May 30 1921

20 UNDERTAKER — ADDRESS

George H Holland 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 54118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54118

CERTIFICATE OF DEATH.

167

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hosp St. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Pikar

(Residence in Baltimore: No. 613 n Road.

St.; (yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Boy

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE 4 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balt

PARENTS.

10-NAME OF FATHER, Joseph Pekar

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Ekeri

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Pekar

(Address) 613 N Lond st

15-

Filed MAY 29 1921 ROBERT A KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ....., May 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns infected plaques
Stomach
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus	May 30, 1921
20-UNDERTAKER	ADDRESS
Grace Evans & Son	1706 Eastern Ave

N.B.—Every item of information should be given in this CERTIFICATE, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. All information is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54119

CERTIFICATE OF DEATH.

151 D 54119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 Gough ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Kokoszka

(a) RESIDENCE. NO. 2110 Gough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 25, 1921

7 AGE: Years | Months | Days: 3 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: George Kokoszka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Helen Wilczynska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Stella Kokoska (Address) 2116 Gough st

15 Filed: MAY 29 1921 ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1921, to May 28, 1921, that I last saw her alive on May 27, 1921, and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Both Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Russell M. D.

(Address) 5/25/21 Lutherville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	May 29 1921

20 UNDERTAKER: John F Weber ADDRESS: 1803 Bank 17

CAUSE OF DEATH in plain terms, so that it may be classified. Do not use abbreviations or terms not generally understood. See instructions on back of certificate. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54120

CERTIFICATE OF DEATH.

109 D 54120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ~~St.~~ 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Sidlowski

(a) RESIDENCE. No. 1334 Reynolds St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Joe Sidlowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Hospital Records
(Address) New City Hospital.

15 Filed MAY 29 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH must be stated for every death, no matter how long attended. INFORMATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to May 26, 1921, that I last saw him alive on May 26, 1921, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Ventral Hernia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post-operative Shock

Hemorrhage (duration) yrs. mos 5 hrs ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? yes Date of 5-26-21

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) F. A. Holden, M. D.

5/26/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 30 1921

20 UNDERTAKER: John M. Weber ADDRESS: 1803 Bank

Spec.—8-24-14—M. & T.—2000 Blks. Blazek

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54121
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

79 D 54121
REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2750 E. Chase ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Blazek

(Residence in Baltimore: No. 2250 E Chase St St.; 37 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, ..., (Month) (Day) 1839 (Year)

7-AGE, 82 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ---

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Chas Sponar

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER don't know

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. W. Blazek

(Address) 2750 E. Chase St.

15- Filed MAY 29 1921 ROBERT J. BRUTLER Registrar.
Burial Permit

CAUSE OF DEATH to be plainly written. Every question must be answered if important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 27 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 1920, to May 26 1921, that I saw her alive on May 26 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic) unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis (Duration) yrs. mos. ds.

(Signed) Frank X Byrd M. D.

May 27, 1921 (Address) 2005 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Most Holy Redeemer — DATE OF BURIAL, May 30, 1921

20-UNDERTAKER Margaret G. Flynn — ADDRESS 1422 Light St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Carrado.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54122

CERTIFICATE OF DEATH.

79 D 54122

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Decatur - ST.: 23d WARD)

2-FULL NAME Frank Carrado

(a) RESIDENCE. NO. 1402 Decatur ST., 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Carrado

6 DATE OF BIRTH (month, day, and year) May 20. 1827

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	94	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wks. Attendant

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canary Islands.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Wm. Carrado. (Address) 801 Edmondson Ave.

15 Filed MAY 29 1921 ROBERT S. KRAETER Registrar

Burial Permit Issued

CAUSE OF DEATH. Physician's particular attention to this portion of certificate is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1921, to May 27, 1921, that I last saw him alive on May 26, 1921, and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Wm. T. Swaney, M. D.

5/28, 1921 (Address) 638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	May 30 1921
20 UNDERTAKER	ADDRESS
Wm J E Evans & Sons	1425 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54123

REGISTERED NO. 19 D 54123

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Hanover ST.: 23 WARD)

2-FULL NAME Ann R. Wingate

(a) RESIDENCE. NO. 1912 Hanover ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Zachariah Wingate

6 DATE OF BIRTH (month, day, and year) May 19 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71		7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 837
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER William Shirley

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER E. Hawley

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Zachariah Wingate
(Address) 1912 Hanover St

15 MAY 29 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1921, to May 26, 1921, that I last saw h alive on May 26, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Arteriosclerosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debilitation (duration) 2 Years yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) T. B. Campbell M. D.

5/25 1921 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: May 30, 1921

20 UNDERTAKER: Mrs J E Evans & Son — ADDRESS: 1428 Pennsylvania Ave

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54124

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54124

CERTIFICATE OF DEATH.

82-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sibley

(a) RESIDENCE. No. Unknown ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White ~~Colored~~	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed MAY 29 1921 ROBERT J. BRAUTIGAM Registrar
Burial Permit Clerk

CAUSE OF DEATH may be typewritten or printed in ink. DUPLICATE CERTIFICATE must be made on back of certificates. ATTENTION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1921

17 I HEREBY CERTIFY, That I attended deceased from September 17 1919, to May 28, 1921, that I last saw her alive on May 27, 1921, and that death occurred, on the date stated above, at 1:45 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.
Old cerebral thrombosis.
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) ..... yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) V. A. Heverman M. D.

5/28/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Offord, Talbot Co. Md.	May 30 1921

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54125

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54125

CERTIFICATE OF DEATH.

REGISTERED NO. 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 Potomac St. Brooklyn ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry M. Hemstetter

(a) RESIDENCE. NO. 530 Potomac st Brooklyn ST. WARD. Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none yet

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Brooklyn Maryland

PARENTS

10 NAME OF FATHER Fred Hemstetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn Maryland

12 MAIDEN NAME OF MOTHER Edna M. Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant (Address) Harry Hemstetter 530 Potomac st Brooklyn Md.

15 Filed MAY 29 1921 19... ROBERT J. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1921

17 I HEREBY CERTIFY, That I attended deceased from May 21st 1921, to May 28th 1921, that I last saw him alive on May 28th 1921, and that death occurred, on the date stated above, at 6 0 m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry Reichel M. D.

5/29, 1921 (Address) 1224 Hanover st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL May 30 1921

20 UNDERTAKER JOHN F. DENNY

ADDRESS 711 LIGHT ST.

CAUSE OF DEATH: Please write plainly. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

148044

D 54126/26

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54126

X 146 D 54126

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Benjamin Gildersleeve.

(a) RESIDENCE. No. Damascus Virginia ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. Gildersleeve. Same address

6 DATE OF BIRTH (month, day, and year) Jan 19 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. Extract works.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Benjamin Gildersleeve

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mary Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Johns Hopkins Hospital Records
(Address)

15 Filed MAY 29 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1921

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1921, to May 29, 1921, that I last saw h im alive on May 29, 1921, and that death occurred, on the date stated above, at 2 40 a m.

The CAUSE OF DEATH* was as follows:

Brain Abscess following an acute Sinusitis

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Damascus Va

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Yes. Blood Temp. Leko

(Signed) V. R. Mason, M. D.

5-29, 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Damascus. Va	May 29 1921

20 UNDERTAKER John O Mitchell ADDRESS 1201 Fayette

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

54127

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54127

30

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N ann ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorathy v Gink

(a) RESIDENCE. NO. 413 N ann ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8-1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Rudolph Gink

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Frances Hitrow

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Rudolph Gink
(Address) 413 N Caroline St

15 Filed MAY 30 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1921, to May 27, 1921, that I last saw her alive on May 27, 1921, and that death occurred, on the date stated above, at 8.40 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. about mos. 16 ds.

CONTRIBUTORY (Secondary) ...

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Laboratory

(Signed) Walter C. Bacon, M. D.

5/28, 1921 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	May 30 1921
20 UNDERTAKER	ADDRESS
Wm F. Hartley	8 S Howard St

CAUSE OF DEATH must be given in plain terms. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

145389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54128

D 54128

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Jenkins.

(a) RESIDENCE. NO. 1106 N. Carrollton Ave ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 7- 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Phillip P. Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Lucinda Bellamy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant (Address) Johns Hopkins Hospital Record

15 Filed MAY 3 0 1921 Registrar

Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28. 1921

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1921, to May 28, 1921, that I last saw her alive on May 28, 1921, and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. 4 mos. 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Positive Wassermann

(Signed) Horton Casparis, M. D.

5 28, 1921 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	May 31 1921
20 UNDERTAKER	ADDRESS 878
Samuel Hemsley	Biddle

CAUSE OF DEATH in plain terms, so that it may be understood by persons not familiar with medical terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 VD 54129

D 54129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Orchard Ave ST., 26 WARD)

2-FULL NAME Lucy O. Walter

(a) RESIDENCE NO. Orchard Ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Walter

6 DATE OF BIRTH (month, day, and year) May 6, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John C. Blackburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Kenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Lucille Daughter

(Address) Orchard Ave, Ruxton Md.

15 Filed MAY 30 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1921.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to May 26, 1921.

that I last saw h. alive on May 24, 1921.

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. 15 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Williamson, M. D.

, 19 (Address) Ruxton, Balt. Co. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemy	5-30- 1921
20 UNDERTAKER John A. Doran	ADDRESS 3000 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 54130 HEALTH DEPARTMENT—CITY OF BALTIMORE

30 D 54130

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1666 E. Darley ave. ST.; 8 WARD)

2-FULL NAME Bernadetta Connor

(a) RESIDENCE. No. 1666 E. Darley ave. ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) apr. 19-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Nellie Horan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Nellie Connor

(Address) 1666 Darley ave.

15 Filed MAY 30 1921 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-27-1921

17 I HEREBY CERTIFY, That I attended deceased from May-8, 1921, to May-27, 1921, that I last saw her alive on May-26, 1921, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis and Exhaustion

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Tuberculosis Meningitis.

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William F. Schwartz, M. D.

May 30, 1921 (Address) 200 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	5-30-1921
20 UNDERTAKER J. A. Inoran	ADDRESS 3000 E. Balto St.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54131

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54131

CERTIFICATE OF DEATH.

REGISTERED NO. 69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Magnora Davis

(a) RESIDENCE. NO. Mount Hope Retreat ST. 28 WARD. (Resident)

(Usual place of abode) Transferred from Springfield Asylum Nov 27-1912 (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? 63 yrs. 1 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Davis-

6 DATE OF BIRTH (month, day, and year) April-15-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savannah Ga

PARENTS

10 NAME OF FATHER Jas. Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora (Sullivan?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Savannah Ga-

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md-

15 MAY 30 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from Nov 27th, 1912, to May 29th, 1921, that I last saw h[illegible] alive on May 28th, 1921, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Epilepsy (Status Epilepticus Comp. by Pul. Edema)

over (duration) 9 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Mania Chr. Post Epilepsy-

over (duration) 9 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Savannah Ga (?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 29th 1921 (Address) Mt Hope Retreat-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 30 1921
20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS: 108 W. NORTH AVE.

CAUSE OF DEATH to be plainly written, and TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54132

D 54132

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Hackett (or Ligori)

(a) RESIDENCE. No. Mt Hope Retreat ST., 28th WARD. (Providence - R.I.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? 60 yrs. 8 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious - 065

(b) General nature of industry, business, or establishment in which employed (or employer) Church Work -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Providence R. I.

PARENTS

10 NAME OF FATHER Charles Hackett

11 BIRTHPLACE OF FATHER (city or town) New Brunswick (State or country) N. Scotia -

12 MAIDEN NAME OF MOTHER Jane Morris

13 BIRTHPLACE OF MOTHER (city or town) N. Brunswick (State or country) N. Scotia -

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md

15 Filed MAY 30 1921 UTLE Registrar 01

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 23rd 1920, to May 24th 1921, that I last saw h.. alive on May 28th 1921, and that death occurred, on the date stated above, at 12.15 A m.

The CAUSE OF DEATH* was as follows:

Paralysis Chr - Post Cerebral Hemorrhage (Eclampsia)

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia - Post Paralysis

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Emmitsburg Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

May 29 19 (Address) Mt Hope Md -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hope Cemetery	May 30th 1921
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM P. MOWEN, Manager)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain words, so that a layman may understand. Omissions are frequent and serious. ATTENDING PHYSICIAN is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54133

CERTIFICATE OF DEATH.

130 D 54133

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1112 W. Franklin ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Hazazer

(a) RESIDENCE. NO. 1112 W. Franklin ST., WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 89 yrs. 6 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) Nov-15-1831

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	89	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware Business

(c) Name of employer (Self)

9 BIRTHPLACE (city or town) (State or country) Philadelphia Penna

PARENTS

10 NAME OF FATHER Joseph Hazazer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Penna

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known not known

14 Informant Miss Florence E Hazazer (niece)
(Address) 1112 W. Franklin St

15 Filed MAY 30 1921 Registrar

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 25th 1920, to May 29th 1921, that I last saw him alive on May 24th 1921, and that death occurred, on the date stated above, at 1:50 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Nephritis
Supervened by Age. (81 years)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion Postmortem

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) E. Hirsch M. D.

May 29 1921 (Address) 601 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	May 30 1921.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM P. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54134

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 D 54134

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 337 E 25 ST.: 12 WARD)

2-FULL NAME Ellen C Frizzell

(a) RESIDENCE. No. 337 E 25 ST.,..... WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Frizzell

6 DATE OF BIRTH (month, day, and year) Oct. 8 - 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Cornelius Loughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Miss A. Frizzell 337 E. 25th St.

15 Filed MAY 30 1921 Registrar

Burial Permit Clerk

CAUSE OF DEATH on back of certificates. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1920, to May 25, 1921, that I last saw h[illegible] alive on May 20, 1921, and that death occurred, on the date stated above, at 7.36 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? Yes Gastric Growth. Cachexia

What test confirmed diagnosis? Symptoms & Emaciation

(Signed) R. P. Carman, M. D.

5-30 1921 (Address) 1701 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk Cem	5/31 1921
20 UNDERTAKER	ADDRESS
J. Few McCully	130 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54135 ✓ D 54135

X 92

CERTIFICATE OF DEATH.

D 54135

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hospital (ST.) 16 (WARD)

2-FULL NAME Mrs Virginia Dick

(a) RESIDENCE. (No.) 1824 Riggs Av. Baltimore Md (WARD.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Floyd W. Dick.

6 DATE OF BIRTH (month, day, and year) March 1st 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER N. Jackson Bee.

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Morrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Virginia

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAY 30 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1921

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1921, to May 29, 1921, that I last saw h Er alive on May 29, 1921, and that death occurred, on the date stated above, at 9 15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) V. K. Mason M. D.

5-27, 19 21 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 31-21
20 UNDERTAKER	ADDRESS
T. Bertram Gore	1733 E. Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 54136 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54136

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Monastery Ave WARD 20)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J Gabrighurst.

(a) RESIDENCE. NO. 208 Monastery Ave STR. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George C Gabrighurst

6 DATE OF BIRTH (month, day, and year) Dec 28, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Saml. Gabrighs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Susannah Monmonier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Carolla N. Gabrighurst
(Address) 208 Monastery

15 Filed MAY 30 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1921

17 I HEREBY CERTIFY, That I attended deceased from November 1, 1920 to May 28, 1921
that I last saw h[illegible] alive on May 29, 1921
and that death occurred, on the date stated above, at 8.05 P m.
The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) yrs. 7 mos. 0 ds.

CONTRIBUTORY (Secondary) Myocarditis Acute Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Chemical analysis of urine

(Signed) Thos A Stevens, M. D.

May 28 1921 (Address) 2866 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Charles Cemetery Pikesville	May 31 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S. Pace St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 54137

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Linton

(a) RESIDENCE. No 1027 Baldwin St ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15-1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4	16		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Linton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katie Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed MAY 30 1921 19 C. I. Mills Registrar Female Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 - 1921

17 I HEREBY CERTIFY, That I attended deceased from May 27 - 1921 to May 28 - 1921 that I last saw her alive on May 28 - 1921 and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (Cause unknown)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 30 1921
20 UNDERTAKER	ADDRESS
James Dignan & Son	102 S Paca St

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54138

D 54138

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1529 N. Washington ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David E. Foster

(a) RESIDENCE. No. 1529 N. Washington ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary E. Foster

6 DATE OF BIRTH (month, day, and year) May 16-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
59	59		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 59

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER David B. Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Elizabeth Free

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City Md.

14 Informant Mary E. Foster

(Address) 529 N. Washington ave.

15 Filed MAY 30 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from April 28th 1921, to May 29th 1921, that I last saw h wife alive on May 27th 1921, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cerebritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

May 29, 1921 (Address) 1501 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 30 1921

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

CAUSE OF DEATH must be filled in plainly, in ink or typewriter, and without abbreviations. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54139

CERTIFICATE OF DEATH.

44 D 54139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3100 Presbury ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Edwin Bird

(a) RESIDENCE. No. 3100 Presbury ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Conn Bird

6 DATE OF BIRTH (month, day, and year) Sept 27 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister 018

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Bird

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Kingston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary E Bird (Address) 3100 Presbury Ave

15 Filed MAY 30 1921 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28" 1921

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1921, to May 28", 1921, that I last saw him alive on May 27" 1921, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ear and Brain

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac paralysis.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? don't know

Did an operation precede death? Yes Date of July 1920

Was there an autopsy? No

What test confirmed diagnosis? Pathologist and

(Signed) Herbert E. Zepp, M. D.

5/29 1921 (Address) 3050 N. Wolfe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	May 30 1921

20 UNDERTAKER Wm J. Tuckey Sons ADDRESS Catonsville

CAUSE OF DEATH to be plainly written. Answer every question. Use ink. Do not use lead pencil. Do not write on back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1009 Bks.

D 54140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54140

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2209 Mt Holly St.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Edward George

(a) RESIDENCE. No. 2209 Mt Holly ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian G. George

6 DATE OF BIRTH (month, day, and year) Dec 14—1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 186

(b) General nature of industry, business, or establishment in which employed (or employer) Picture frames

(c) Name of employer Northumberland Co

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ~~Robt Evans~~ (Wm Lloyd?)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER May Maith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Lillian G. George

(Address) 2209 Mt Holly St.

15 Filed MAY 30 1921 [illegible] KRAUTER Registrar

Postal Form 11 Old

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 21

17

I HEREBY CERTIFY, That I attended deceased from — 1917, to May 28 1921, that I last saw h— alive on May 27 1921, and that death occurred, on the date stated above, at 6 3/4 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) — yrs. — mos. 20 ds.

18 Where was disease contracted if not at place of death? Yes Place of Death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Edgar S. Luttrell, M. D.

, 19 (Address) 2329 St. Paul St. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 31 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

CAUSE OF DEATH must be stated plainly. Certificates. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54141

CERTIFICATE OF DEATH.

29

D 54141

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1155 W. Cross ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Reynolds.

(a) RESIDENCE. No. 1155 W. Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John J. Reynolds.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Dorn

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs. Catherine Reynolds.
(Address) 1155 W. Cross St.

15 Filed MAY 30 1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1921

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 28, 1921, that I last saw h[illegible] alive on May 28, 1921, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

1. Cause Miliary Tuberculosis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward Kerbaker, M. D.

, 19 (Address) 24 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	May 30 1921
20 UNDERTAKER	ADDRESS
Lilly & Zuke.	403½ Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificate may be returned for correction if CAUSE OF DEATH is not sufficiently explained. Do not use abbreviations or technical terms. Consult physician if necessary. See instructions on back of certificates. INFORMATION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 175-001 D 54142

D 54142

CERTIFICATE OF DEATH.

Registered No. C

1-PLACE OF DEATH

City of Baltimore (No. N. G. U. St.: 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph L Knapp

(Residence in Baltimore: No. 1834 Waltemyer court St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	single

6-DATE OF BIRTH, March 3rd, 1918.
(Month) (Day) (Year)

7-AGE, 3 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Harry L Knapp

11-BIRTHPLACE OF FATHER (State or Country) Baltimore City

12-MAIDEN NAME OF MOTHER Annie L Schisler

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry L Knapp

(Address) 1834 Waltemyer Ct.

15- ROBERT F KRAUTER

Filed MAY 30 1921 19... Registrar. Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull

2 hrs.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) automobile accident

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. T. Hennessy M. D.
(Coroner.)

May 29, 1921 (Address) 2802 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters Cem	May 30, 1921
20-UNDERTAKER	ADDRESS
Martin Fahey & Sons	827 N North Ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54143

CERTIFICATE OF DEATH.

79 D 54143

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 N. Eden St ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jake Ely

(a) RESIDENCE. No. 106 N. Eden St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	11	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Asriel Ely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lena Caplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1411 Druid Hill Ave

15 Filed MAY 30 1921 19 Registered ROBERT A. FEILDER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1921

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1921, to May 30, 1921, that I last saw him alive on May 30, 1921, and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Acute Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Baylis, M. D.

5/30 1921 (Address) 210 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL 5/30 1921

20 UNDERTAKER Jack Lewis ADDRESS 1411 Druid Hill Ave

CAUSE OF DEATH must be stated plainly. Do not use abbreviations or initials. Do not state mode of dying, such as heart failure, asthenia, etc., but the disease or injury which caused death. TION is very important. See instructions on back of certificates.

Polk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54144

CERTIFICATE OF DEATH.

155 D 54144

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 718 N Curley ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas H Pack

(Residence in Baltimore: No. 718 N Curley St.; yrs. 33 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Dec 17, 1888
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 166

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frederick Pack

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Celia Tatar

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Chas N. Pack

(Address) 718 N Curley St

15-

Filed MAY 30 1921 ROBERT J. BRUTER Registrar of Births

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Drinking Carbolic Acid

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Lyon Weber M. D.
(Coroner)

May 30, 1921 (Address) 1604 E Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	May 31, 1921
20-UNDERTAKER	ADDRESS
Jos. J. Iden	156 N. Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54145 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54145

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 St Paul ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Alfred Conner

(a) RESIDENCE. NO. 910 St. Paul ST., 11 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Eleanor Torrance

6 DATE OF BIRTH (month, day, and year) June 5th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk U.S. Customs House

(b) General nature of Industry, business, or establishment in which employed (or employer) Not Known

(c) Name of employer U. S. 004

9 BIRTHPLACE (city or town) (State or country) Philadelphia Penna

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) J. Bannister Wall Jr. 627 E. Lexington Old Town Md.

15 Filed MAY 30 1921 Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th 1921

17 I HEREBY CERTIFY, That I attended deceased from May 14th, 1921, to May 29th, 1921, that I last saw him alive on May 29th, 1921, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis and Arterio-Sclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopical

(Signed) William J. Pressick, M. D.

5/29/ 1921 (Address) 1700 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 5-31 1921

20 UNDERTAKER Henry W. Jenkins Sons Co

ADDRESS Orchard & McCulloh

CAUSE OF DEATH ... See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54146

D 54146

CERTIFICATE OF DEATH.

130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Somerset ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Weston R. Brown

(a) RESIDENCE. NO. 518 Somerset ST., ... WARD. ...

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 65 Years — Months — Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 004

(b) General nature of industry, business, or establishment in which employed (or employer) Barber

(c) Name of employer For him self

9 BIRTHPLACE (city or town) born in Balt-
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Wife Dora Reny Brown

(Address) 518 Somerset St

15 Filed MAY 30 1921 ROBERT P. PRUITT Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1921

17

I HEREBY CERTIFY, That I attended deceased from May 9, 1921, to May 28, 1921, that I last saw h[illegible] alive on May 27, 1921, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. H. C. Robinson M. D.

May 30, 1921 (Address) 523 Monument E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	May 30 1921
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

CAUSE OF DEATH in plain terms, as from [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54147 ✓ D 54147

CERTIFICATE OF DEATH.

REGISTERED NO. 37

D 54147

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: NO. ..... ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Dixon

(a) RESIDENCE. NO. 710 Penn Alley ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 921

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer

9 BIRTHPLACE (city or town) born in Balt- Maryland
(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) Talbot Shores Md
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) born in Balt- O.
(State or country) Ellen Barton

14 Informant Bay View Hospital
(Address) Baltimore, Md.

15 Filed MAY 30 1921 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1921 to May 29, 1921.

that I last saw h[illegible] alive on May 28, 1921.

and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (8 the insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lutic Conjectum

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Sinkus

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) H. S. Goldsmith M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 30 1921

20 UNDERTAKER Mrs Robert & Elliott Ashland

ADDRESS 1725 Aq

mation should be given, so that it may be properly ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

D 54148

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54148

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. U. C. D., ST.: 14 WARD)

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Batz

(Residence in Baltimore: No. Owings Mills, Md. St.; 52 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, March 2, 1869
(Month) (Day) (Year)

7-AGE, 52 yrs. 2 mon. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Repair worker
(b) General nature of industry, business, or establishment in which employed (or employer)..... Steam R. R.

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, John Batz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Annie Fox

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Loretta Batz

(Address) Owings Mills, Md.

15- Filed MAY 30 1921, 191.... ROBERT J. SLAUTER
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following an automobile accident in which L. L. had right femur fractured & many contusions of head & face (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Traumatic pneumonia (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

May 31, 1921 (Address) 2802 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mills Cem	5/31/21 19....

20-UNDERTAKER J. P. Elmer ADDRESS Reisterstown

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omissions important. See instructions on back of certificate.

D 54149

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D 54149

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No 808 Dukeland Ave St. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Amanda J. Green

(Residence in Baltimore: No. 808 Dukeland Ave St.: 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, ~~MARRIED~~ WIDOWED ~~DIVORCED~~ (Write the word): Widow

6 DATE OF BIRTH: May 31, 1842 (Month) (Day) (Year)

7 AGE: 79 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Manchester Carroll Co

PARENTS

10 NAME OF FATHER: Richard Gelear

11 BIRTHPLACE OF FATHER (State or country): Baltimore City

12 MAIDEN NAME OF MOTHER: Elizabeth Small

13 BIRTHPLACE OF MOTHER (State or country): Baltimore City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed. Benning

(Address) 507 N. Schroeder

15. Filed MAY 3 0 1921 ROBERT J. KRAUTER Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May 28, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to May 28, 1921, that I saw her alive on May 28, 1921, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Ac. Interstitial Nephritis

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Anemia

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Colin Munro M. D.

May 30, 1921 (Address) 1271 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: May 31 1921

20 UNDERTAKER: Ed. Benning — ADDRESS 507 N. Schroeder St

N.B.–Every item of information should be carefully supplied. Any item omitted may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54150

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D 54150

REGISTERED NO.....

1-PLACE OF DEATH Nursery & Child's Hosp.

CITY OF BALTIMORE: (No. Baltimore Md. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Morguerite Hartman

(a) RESIDENCE. No. Nursery & Child's Hospital ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Lamartina

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Rhoda Hartman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Rhoda Hartman
(Address) Childs Hagerstown

15 Filed MAY 30 1921 Burial permit issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1921, to May 29, 1921, that I last saw h.. alive on May 29, 1921, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) I. J. Feinglass, M. D.

. 19 (Address) 2002 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 31 1921
20 UNDERTAKER Geo J Smith	ADDRESS 1000 Pa

CAUSE OF DEATH must be plainly written, and all questions answered. See instructions on back of certificates. TION is very important.

D 54151 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177 D 54151

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph's Hosp. St.) Ward 8

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Jenke.

(Residence in Baltimore: No. 1921 N Hollington Ave. Yrs. 85 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: About (Month) ..... (Day) 1836 (Year)

7-AGE: 85 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Conrad Ohmer

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Upknap

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Louis Hekler

(Address) 553 Numsen St.

15- MAY 30 1921 [redacted] DEATH

Filed ....., 191.....

[redacted]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: May (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism fell

down stairs (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Kurt Smith M. D.

(Coroner)

5-29-1921 (Address) M E Dept

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cem't | DATE OF BURIAL: May 31 1921

20-UNDERTAKER: Wm Cook | ADDRESS: 502 E North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Coroner Insley 2738 E Balt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54152

54152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 622 South Wolfe ST.; 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward O. Illsman

(a) RESIDENCE. No. 622 South Wolfe ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Illsman

6 DATE OF BIRTH (month, day, and year): Jan 6-1888

7 AGE — Years: 33 — Months: 4 — Days: 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: William Illsman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Annie Illsman 622 South Wolfe

15 Filed MAY 30 1921, 19 ROBERT I. BRAUER Registrar

Ward 3 36th Elec.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1921

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to May 28, 1921, that I last saw him alive on May 28, 1921, and that death occurred, on the date stated above, at 7:10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Exposure in army

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Maryland

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) E. O. Illsman, M. D.

May 29 1921 (Address) 865 N. 36

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: May 31 1921

20 UNDERTAKER: William Cook — ADDRESS: 50 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8

D 54153

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund Schorr

(a) RESIDENCE. NO. 610 Bartlett Av. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 17 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Edna Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John R. Schorr (Address) 610 Bartlett Ave

15 Filed MAY 30 1921 ROBERT I. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1921

17 I HEREBY CERTIFY, That I attended deceased from May 27. 1921. to May 29. 1921. that I last saw him alive on May 29. 1921. and that death occurred, on the date stated above, at 9 00 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) Encephalitis

(duration) yrs. mos. 4 [illegible]

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis A. K Emery, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park C	May 30 1921
20 UNDERTAKER William Cook	ADDRESS 502 E Nort

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54154

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54154

CERTIFICATE OF DEATH.

42

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1715 W. Lafayette Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Wordward Horne

(a) RESIDENCE. NO. 1715 W Lafayette Ave ST. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George W. Horne

6 DATE OF BIRTH (month, day, and year) Dec 5 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Dod

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm F. Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Florence L. Smith

(Address) 1710 W. Lafayette Ave

15 Filed MAY 30 1921 19 ..... Registrar

Certificate to 22 W Lafayette Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1921

17 I HEREBY CERTIFY, That I attended deceased from October 14, 1921, to May 29, 1921, that I last saw her alive on May 28, 1921, and that death occurred, on the date stated above, at 4.25 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home & death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Microscopic examination specimen

(Signed) H M Slemmer M. D.

May 30. 1921 (Address) 1022 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 31 1921

20 UNDERTAKER Wm Cook

ADDRESS 502 E. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(See affadavit over) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54155

D 54155

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Estelle Marshall

(a) RESIDENCE. NO. 1931 Druid Hill Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Va

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Warsaw Richmond Co. Va

PARENTS

10 NAME OF FATHER George Washington

11 BIRTHPLACE OF FATHER (city or town) Warsaw
(State or country) Richmond Co Va

12 MAIDEN NAME OF MOTHER Sallie Bowser

13 BIRTHPLACE OF MOTHER (city or town) Warsaw
(State or country) Richmond Co. Va

14 Informant Mrs Sallie Washington
(Address) 344 N. Kentucky ave Atty

15 Filed MAY 30 1921 ROBERT J. BRADY Registrar
Rachel Powell Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/28/ 1921

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to May 28, 1921, that I last saw h[illegible] alive on May 28, 1921, and that death occurred, on the date stated above, at 7.20 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? P.M. Findings

(Signed) Charles A Donovan, M. D.

, 19 (Address) 5-E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 5/31 1921

20 UNDERTAKER

ADDRESS 102 E. Mulberry St. City

CAUSE OF DEATH: Fill in the proper answers to each question. See instructions on back of certificates. TION is very important.

Baltimore, Md., June 1, 1921.

I do hereby make oath that the name of deceased given on Baltimore City Health Department Certificate of Death - D54155, as Lucille Marshall is not correct; that same should be recorded as Susie Marshall.

Edward O'Donovan

Physician.

Subscribed and sworn to before me this 1st day of June,

Reed Gaither

Notary Public.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54156

CERTIFICATE OF DEATH.

28 ✓ D 54156

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hosp. ST., 17 WARD.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Lewis.

(a) RESIDENCE. No. 355 Monroe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 840

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Frank Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Sadie Carter (Friend) (Address) 563 Oxford Street

15 MAY 3 01921 ROBERT I. FRAUTEN Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1921, to May 28, 1921, that I last saw him alive on May 28, 1921, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Sputum X-ray

(Signed) L. J. Rigney, M. D.

19 (Address) Municipal Tuberculosis Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: May 30 1921

20 UNDERTAKER: Jno. M. Johnson

ADDRESS 1224 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Do not use abbreviations or technical terms. Diseases of women and children should be specially designated. Name contributory (secondary) causes, if any, which may have aggravated the disease causing death. Operations should be mentioned, with the disease for which they were performed. Violent deaths must be fully explained. Write plainly in ink. Fill in all blanks with the best information obtainable. Physicians are requested to fill in the certificate of death and return it to the undertaker. Information as to the medical facts of death is required by law, and is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54157

CERTIFICATE OF DEATH.

50 D 54157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Aprt., ST. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Frank,

(a) RESIDENCE. No. Esplanade Aprt., ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred lifetime, yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabella Frank,

6 DATE OF BIRTH (month, day, and year) July 20th. 1844.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Mrcht.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired, OH5

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Germany~~ Balto. Md.

PARENTS

10 NAME OF FATHER Henry Frank,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER Sarah Truehart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany,

14 Informant Eli Frank,

(Address) Equitable Bldg.

15 DATE RECEIVED MAY 3 0 1921 Burial Permit Issued

CAUSE OF DEATH in plain, ordinary language. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th. 19 21

17

I HEREBY CERTIFY, That I attended deceased from ....., 19 00, to May 29, 19 21,

that I last saw h.. alive on May 29, 19 21,

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

Arterio-sclerosis; angina pectoris

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute gastro-enteritis

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Glycosuria, hypertension

(Signed) Harry Adler, M. D.

, 19 (Address) 1718 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew,

DATE OF BURIAL May 31th, 21

20 UNDERTAKER David Goudheim

ADDRESS 118 N. Mt Royal Av

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54158

CERTIFICATE OF DEATH.

159 ✓ D 54158

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1342 N. Freemans St.; 16 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Bigham

(Residence in Baltimore: No. 1342 N. Freemans St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	colored	married

6-DATE OF BIRTH, ... November ..... (Month) ..... (Day) ....., 1869 (Year)

7-AGE, 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Minister
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Wash. D.C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Bruglone

(Address) 1102 Monument St

15- MAY 30 1921 191..... ROBERT J KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May ..... (Month) ..... 28 (Day) ....., 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... I ..... (Inquest, autopsy or inquiry.) ..... find that said deceased came to ..... his ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by automobile
of head (fracture of skull)
(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy ..... M. D.
(Coroner.)

May 31, 1921 (Address) 2802 Eastern Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	May 30, 1921
20-UNDERTAKER	ADDRESS
Edw. Ruggold	1463 W. Lanvale St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54159

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54159

CERTIFICATE OF DEATH.

91 V52/139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 251 S. Central ave ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Granoschi

(a) RESIDENCE. NO. 251 S. Central ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 2-1919

7 AGE 1 Years 6 Months 28 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Raffaele Granoschi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maria G. Italy

12 MAIDEN NAME OF MOTHER Maria G. Maggio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Raffaele Granoschi
(Address) 251 S. Central ave

15 FILED MAY 31 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30/21

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1921, to May 30, 1921, that I last saw h[illegible] alive on May 30, 1921, and that death occurred, on the date stated above, at 8. 2. m.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. J. Valentine, M. D.

May 26 1921 (Address) 412 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	5/31/21

20 UNDERTAKER Geo. D. Ruth ADDRESS 1735 Aisquith ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54160

CERTIFICATE OF DEATH.

79 ✓ D 54160

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 E Biddle St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary V. Farrell

(Residence in Baltimore: No. 2414 E. Biddle St. St.; 15 yrs., ___ mos. ___ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	Colored	single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 70 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Self.

9-BIRTHPLACE, (State or Country). Charles Co. Md

PARENTS.

10-NAME OF FATHER. William Farrell

11-BIRTHPLACE OF FATHER (State or Country). Charles Co. Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph A Farrell

(Address) 2319 Division St

15- MAY 31 1921 Filed ....., 191.... ROBERT J. LAUTER Registrar

Burial or Removal Certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29", 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20 1921, to May 29 1921, that I saw her alive on May 27 1921, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Cancer of the Rectum

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Thos B Reed M. D.

May 29, 1921. (Address) 1017 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	June 1, 1921
20-UNDERTAKER Joseph a Farrell	ADDRESS 2319 Division st

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54161

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

29

D 54161

REGISTERED NO. C

CITY OF BALTIMORE (No. 532 N. Franklin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. N. Hennebergen

(Residence in Baltimore: No. 532 N. Franklin St. St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Married

6-DATE OF BIRTH, April 28, 1860
(Month) (Day) (Year)

7-AGE, 60 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Hiram Hennebergen

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eliz. Hennebergen

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. C. Hennebergen

(Address) 532 N. Franklin St

15- Filed MAY 31 1921, 191... ROBERT J. BRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 28, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) yrs. mos. ds.

(Signed) J. C. H. Hennebergen M. D.
(Coroner.)

May 30 1921 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 5/31, 1921

20-UNDERTAKER Jos. H. Bailey ADDRESS Fulton & Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54162 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54162

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 811 Peach alley WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hartie Sipscomb

(a) RESIDENCE. No. 811 Peach alley WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec, 29, 1915

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
5	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Herbert Hall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Lurie Sipscomb

13 BIRTHPLACE OF MOTHER (city or town) Petersville
(State or country) Virginia

14 Informant Charles Sipscomb
(Address) 811 Peach al

15 Filed MAY 31 1921 ROBERT J. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 29 1921

17 I HEREBY CERTIFY, That I attended deceased from May, 26, 1921, to May, 29, 1921, that I last saw him alive on May, 29, 1921, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dan Frumkin, M. D.

May 29, 1921 (Address) 1224 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	May 31 1921
20 UNDERTAKER	ADDRESS
L W Bowman & Son	10 N Monty

CAUSE OF DEATH must be stated plainly, and TION is very important. See instructions on b

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54163

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Van Daniker

(a) RESIDENCE. No. #101 N. Patterson Pk Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Mary Van Daniker

6 DATE OF BIRTH (month, day, and year) Feb 2. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob Van Daniker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Louise Bartholmi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Van Daniker
(Address) 101 N Patterson Park Ave

15 Filed MAY 31 1921 ROBERT S. BRADTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1921 to May 30, 1921, that I last saw him alive on May 30, 1921, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy - Arteriosclerosis
Chr Arterial Hypertension Diffuse Nephritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency Edema Lungs

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. H. Geyer M.D. M. D.

5/30, 1921 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
Western Cem	June 2 1921

20 UNDERTAKER Geo W Little ADDRESS 2700 Edmondson Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Gram)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54164

D 54164

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 Whalcoat ST., 16 WARD)

2-FULL NAME William Gram

(a) RESIDENCE NO. 1028 Whalcoat ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? [illegible] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colred	Maried

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Gertrude Gram

6 DATE OF BIRTH (month, day, and year) Dec 25 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER William Gram

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Gertrude Gram

(Address) 1028 Whalcoat St

15 MAY 31 1921 ROBERT J. LEAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1921, to May 28, 1921.

that I last saw h[illegible] alive on May 26, 1921,

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Findings

(Signed) C. William Frey, M. D.

5/29, 1921 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 31 1921
20 UNDERTAKER	ADDRESS
Clarence L. Wright	1367 Mass

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54165

CERTIFICATE OF DEATH.

8-061 D 54165

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1207 Denver St. Ward 21)

REGISTERED No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise-May Jacob

(a) RESIDENCE. No. 1207 Denver St. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: NONE
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: Wm Jacob
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore
12 MAIDEN NAME OF MOTHER: Jackson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Wm Jacob
(Address) 1207 Denver St

15 Filed MAY 31 1921 ROBERT S. BRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to May 30, 1921, that I last saw her alive on May 30, 1921, and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Meningitis acute
(duration) yrs. mos. one ds.

CONTRIBUTORY (Secondary) Pertussis
(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. C. Engelhardt M. D.

19 (Address) 682 Columbia Ave

5/30/21

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	June 1st 1921
20 UNDERTAKER	ADDRESS
E. Schloman & Son	1034 Lanvale

CAUSE OF DEATH to be plain terms. Abbrevia-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 54166

D 54166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 709 Scott St.; 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Blank

(a) RESIDENCE. No. 709 Scott St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Blank

6 DATE OF BIRTH (month, day, and year) Feb 22 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer S. B. Leyton & Co 58th

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Christoph Blank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary A. Blank

(Address) 709 Scott St.

15 MAY 31 1921 ROBERT J. KLUTER Registrar

Social Service Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1921

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1921, to May 28, 1921, that I last saw him alive on May 28, 1921, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emmett Stoag, M. D.

May 28 1921 (Address) 729 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL May 31 1921

20 UNDERTAKER Wm. J. Pickues & Sons ADDRESS North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

144 D 54167

REGISTERED NO.

1-PLACE OF DEATH S. Balto. Gen. Hosp.

CITY OF BALTIMORE: (No. ..... ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Thompson

(a) RESIDENCE. NO. 28 E. Henrietta ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred 9/0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Thompson

6 DATE OF BIRTH (month, day, and year) Aug - 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer pt.

(c) Name of employer Swift & Co

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Chas Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Anna C. Hurtt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary E. Thompson

(Address) 28 E. Henrietta St

15 Filed MAY 3 1921 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17 1921, to May 30 1921, that I last saw him alive on May 30 1921, and that death occurred, on the date stated above, at 9.10 9 m.

The CAUSE OF DEATH* was as follows:

Multiple abscesses of left lung.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema Necessitatis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 2/23/21

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) L. C. Dobihal, M. D.

19 (Address) S. Balto. Gen. Hosp.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	June 1 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

Postal Record Sheet

CAUSE OF DEATH in plain terms, so that it may be understood by physicians in all parts of the country. See instructions on back of certificates. ATTENTION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54168

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital (ST.; 15 WARD) REGISTERED NO. C 47

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elizabeth Fleischer

(Residence in Baltimore: No. 374 Chestnut Rd. St. 47 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January 26, 1874. (Month) (Day) (Year)

7-AGE, 47 yrs. 4 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis Riedel

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mrs Shoeburn

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Paul Fleischer

(Address) 374 Chestnut Rd.

15- MAY 31 1921 191... ROBERT J. KRAUSE Registrar. Deputy Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 23, 1921, to May 27, 1921, that I saw h[er] alive on May 26, 1921, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

Decompensation for due

to chronic Gallop[ing] Pert[ussis]

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Stomach

(Duration) yrs. mos. ds.

(Signed) Harry Fleischer M. D.

May 30, 1921. (Address) 1340 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence usual

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, May 31, 1921.

20-UNDERTAKER Margaret J. Flynn ADDRESS 1472 Light St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 54169

CERTIFICATE OF DEATH

104 D 54169

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 3702 E. Lombard. St. 26 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myrtle Bell Patterson.

(Residence in Baltimore: No. 3702 E. Lombard St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Infant

6-DATE OF BIRTH: December 31, 1920 (Month) (Day) (Year)

7-AGE: ✓ yrs. 4 mos. 30 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10-NAME OF FATHER: Clarence Patterson.

11-BIRTHPLACE OF FATHER (State or country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Daisey McDonald.

13-BIRTHPLACE OF MOTHER (State or country): Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carry Patterson

(Address) 3607 Mt. Pleasant Av.

15 Filed MAY 31 1921 ROBERT J. BRUCE Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 27, 1921, to May 30 1921, that I saw h[illegible] alive on May 29, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

I Leg Colitis

.....

.....

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen C. Beetham, M. D.

May 30, 1921 (Address) 3134 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: St Marys Hampden

DATE OF BURIAL: June 1, 1921

20-UNDERTAKER: Ebenezer Sons

ADDRESS: Lexington & Eutaw Sts

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. Where it may not be known exactly, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54170

CERTIFICATE OF DEATH

1-PLACE OF DEATH South Baltimore Gen'l. Hospital 40

CITY OF BALTIMORE: (No. 1213 Light ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Kronmaier

(a) RESIDENCE. NO. Sippel Ave., Raspeburg, Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edna Kronmaier

6 DATE OF BIRTH (month, day, and year): Feby 4- 1868

7 AGE: Years 53; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Carl Kronmaier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Leiber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Edna Kronmaier

(Address): Sippel Ave Raspeburg md

15 MAY 31 1921 ROBERT J. FRAZIER Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5 - 30 - 1921

17 I HEREBY CERTIFY, That I attended deceased from May 13 -, 1921, to May 30 -, 1921, that I last saw him alive on May 30 -, 1921, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows: Carcinoma of stomach

(duration) 1 yrs. - mos. - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of 5-27-21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard L Tolson, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: June 2 1921

20 UNDERTAKER: Robt. L. Turner Sr. — ADDRESS: 1x x 24 Barre

CAUSE OF DEATH is plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54171 Huber

CERTIFICATE OF DEATH.

64 D 54171

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 N. Carrollton St.; 17 Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Catharine Huber

(Residence in Baltimore: No. 613 N. Carrollton ave St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. 7

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, February 22, 1851
(Month) (Day) (Year)

7-AGE, 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... home .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... home .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George W King

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Sarah F Shepherd

13-BIRTHPLACE OF MOTHER (State or Country), Cecil Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace F Huber

(Address) 613 Carrollton Ave

15- MAY 31 1921, 191.... .....
Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 17 1916, to May 29 1921, that I saw h[er] alive on May 29 1921, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - right side

(Duration) 5 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) 5 yrs. 1 mos. 1 ds.

(Signed) Wm F King M. D.

May 30 1921 (Address) 1425 N. Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, June 1, 1921

20-UNDERTAKER Geo I Smith

ADDRESS 1208 Fayette st

Cause of death must be stated in this certificate. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54172

CERTIFICATE OF DEATH.

50 D 54172

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2317 E Mount St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Vogt.

(Residence in Baltimore: No. 2317 E Monument St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, April 17, 1874
(Month) (Day) (Year)

7-AGE, 47 yrs. 1 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer.
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Ambrose Vogt

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Mary Bauer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Julia Vogt

(Address) 2317 E. Monument St.

15-

Filed.....Robert P. Harrison, 19..

JY 8 1921 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29, 19V
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May 1 191/ to May 29 191/, that I saw h[illegible] alive on May 29 191/, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

D Cardio Nephritis

(Duration) yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) yrs. ....mos. 1 ....ds.

(Signed) L. Eustace Brady M. D.

....., 191... (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, June 1, 1921.

20-UNDERTAKER Mc Gunnes & Carroll

ADDRESS 4203 Ridgewood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54173 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54173

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Somerset St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherina A. Meyer Hengemuhle

(a) RESIDENCE. No. 1006 Somerset St., Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. Hengemuhle

6 DATE OF BIRTH (month, day, and year) Apr. 3 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Mary Shoemaster
(Address) 1006 Somerset St

15 Filed ..... 19.... Robert P. Harrison, Registrar

MAY 31 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2 1921, to May 30 1921, that I last saw her alive on May 29 1921, and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation (Chronic)

(duration) Not Ascertained yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) Benj. D Hayden M. D.

5/30, 1921 (Address) 1216 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 1 1921
20 UNDERTAKER	ADDRESS
Henry Houck & Son	1301 E. Baltimore

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54174 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54174

CERTIFICATE OF DEATH. 135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1005 E Biddle ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine M Bohli

(a) RESIDENCE. No. 1005 E. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of John J. Bohli

6 DATE OF BIRTH (month, day, and year) November 25 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George H Harlow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Heim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. John J. Bohli (Address) 1005 E Biddle

15 Filed MAY 31 1921 Robert P. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1921, to May 31, 1921, that I last saw h alive on May 31, 1921, and that death occurred, on the date stated above, at 6 00 a.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured uterus - about

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Sanderson, M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 3rd 1921
20 UNDERTAKER	ADDRESS
Henry Hoerl & Son	1301 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. If infant or child, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54175 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54175

(Seniuk)

CERTIFICATE OF DEATH.

169

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3034 Boston ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie ~~Lisiecki~~ Seniuk

(Residence in Baltimore: No. 3034 Boston St.: 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec. 11, 1911
(Month) (Day) (Year)

7-AGE, 9 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Brooklyn N Y

PARENTS.

10-NAME OF FATHER, Alexander Lewek

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Eva Czarnohska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander Lewek

(Address) 3034 Boston St

15-

Filed ..... Robert F. Harrison ..... Registrar.

MAY 31 1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 30, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. P. Russell M. D.
(Coroner)

May 31, 1921 (Address) 806 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Denis Cem

DATE OF BURIAL, June 2, 1921

20-UNDERTAKER Stephen J Stalkowski

ADDRESS 1000 S Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54176 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54176

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Cumberland ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wallace Beyers

(a) RESIDENCE. No. 703 Cumberland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Edw. M. Beyers

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Ella Brayden

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) md

14 Informant Edw. M. Beyers
(Address) 703 Cumberland St

Filed MAY 31 1921 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1921

17

I HEREBY CERTIFY, That I attended deceased from May 28, 1921, to May 29, 1921, that I last saw h... alive on May 29, 1921, and that death occurred, on the date stated above, at 6.20 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion
(Convulsions)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Gastro-Enteritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Brown, M. D.

May 29 1921 (Address) 1837 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cemetery	May 31 1921

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1829 W. Mulberry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54177 ✓ D 54177

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hamilton Baltimore

CITY OF BALTIMORE: (NO. Harford Ave & Maplewood ST.: 37 WARD)

2-FULL NAME Mary M. Gallagher Harford Ave & Maplewood Ave

(a) RESIDENCE. NO. Harford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Gallagher

6 DATE OF BIRTH (month, day, and year) 6/25/1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Williamsport Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant James J. Gallagher (Address) Harford Road.

15 Filed MAY 31 1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to May 29, 1921, that I last saw her alive on May 28, 1921, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Gross, M. D.

5/30 1921 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 1921

20 UNDERTAKER George F. Ruth ADDRESS 1335 Harford ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54178 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54178

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hut Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Constantine Hoitus

(a) RESIDENCE. NO. 718 W Lexington ST. 11 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mall	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Constantine Hoitus

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Greece

12 MAIDEN NAME OF MOTHER Margaret Brand

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Constantine Hoitus
(Address) ~~Clara Harrison,~~

15 Filed ..... 19 .....
Registrar

1 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1921

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1921, to May 27, 1921, that I last saw him alive on May 26, 1921, and that death occurred, on the date stated above, at 7:45 a m.

The CAUSE OF DEATH* was as follows:

Premature 6½ mos

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Hut. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	MAY 29 1921
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of POINTS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54179

CERTIFICATE OF DEATH.

152 D 54179

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Phaneuf

(a) RESIDENCE. No. 5 N. Exeter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 21, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Irene Phaneuf

13 BIRTHPLACE OF MOTHER (city or town) R. I (State or country)

14 Informant R. Riddall (Address)

15 Filed MAY 31 1921, 19.. Harrison, Registrar

Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1921

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1921, to May 23, 1921, that I last saw her alive on May 23, 1921, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

~~Prematurity~~

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Guy U. Cromwell, M. D.

5/25 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. ADDRESS MAY 31 1921

Per. Wm E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54180

D 54180 HEALTH DEPARTMENT—CITY OF BALTIMORE

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST.; 8 11 WARD.)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ridgeway

(a) RESIDENCE. No. 611 E. 30th St ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 28/21

7 AGE Years Months Days If LESS than 1 day, 1 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baeto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Clarence Ridgway

11 BIRTHPLACE OF FATHER (city or town) Baeto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Reigle

13 BIRTHPLACE OF MOTHER (city or town) Baeto. Md.
(State or country)

14 Informant (Address) Robert P. Harrison.

MAY 31 1921, 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1921

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1921, to May 28, 1921, that I last saw h[illegible] alive on May 28, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Fred B. Smith, M. D.

May 31, 1921 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAY 31 1921

20 UNDERTAKER

ADDRESS

Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54181 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54181

CERTIFICATE OF DEATH.

+ 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Memorial Hospital ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Roy Hersberger

(a) RESIDENCE. NO..... ST., ... WARD. Luray, Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 22 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) School boy

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Roy Maria Hersberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sue Row

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Roy Hersberger
(Address) Luray Va.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1921

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1921, to May 31, 1921, that I last saw h.. alive on May 31 1921, and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Operation for Hirschsprung's disease (Congenital Megacolon)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Luray, Va.

Did an operation precede death? Yes Date of May 28, 1921

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) George E. H. Haldy, M. D.

, 19 (Address) Mercy Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Luray Virginia	May 31 1921
20 UNDERTAKER William Cook	ADDRESS 502 E Main

CAUSE OF DEATH in plain terms, so that it may be properly classified. Explanation of abbreviations may be found on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54182

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2119 St Paul St. (WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Baldwin

(a) RESIDENCE. NO. 2119 St Paul St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE Widow Edward Baldwin

6 DATE OF BIRTH (month, day, and year) March 19 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Daniel W Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Mary E Tydings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md

14 Informant Suzanna Baldwin (Address) 2119 St Paul St

15 Filed , 19 Robert F. Karwacki Clerk. Registrar

MAY 31 1921

H Bannister 2125 Calvert St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1924

17 I HEREBY CERTIFY, That I attended deceased from March 17th 1921, to May 30th 1924, that I last saw h alive on May 30th 1924, and that death occurred, on the date stated above, at 2 12 P.M.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease with hepatitis complication

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Date not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. W. Bannister M. D.

19 (Address) 2125 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Annapolis Md June 2 1921

20 UNDERTAKER — ADDRESS

W M Cook 512 E Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54183 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 54183

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Chola Terrace ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Anna Burley

(a) RESIDENCE. NO. 2120 Chola Terrace ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. William E. Burley.

6 DATE OF BIRTH (month, day, and year) April 15 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52 yrs	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER Aquilla Keen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md.

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant Mr. William E. Burley

(Address) 2120 Chola Terrace Md.

15 Filed ... 19 ... Robert P. Harrison, Registrar

MAY 31 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1921

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to May 30, 1921, that I last saw h.er alive on May 30, 1921, and that death occurred, on the date stated above, at 1 20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

from Cystoy (duration) 4 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) ... yrs. ... mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms - Hist. Typical

(Signed) W. S. Hebbett M. D.

May 31 1921 (Address) 2230 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Grove Cemetery Aberdeen Harford Co Md	June 1 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2173 Boone

IMPORTANT—Fill in all items, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54184

HEALTH DEPARTMENT—CITY OF BALTIMORE

43 D 54184

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Newington Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie H. Haldeman

(a) RESIDENCE. NO. 821 Newington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C Haldeman

6 DATE OF BIRTH (month, day, and year) Dec 26 - 1884

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
36	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER D. Geo Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Nora E Steffe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant D. G. Shipley (Address) 821 Newington Ave

15 Filed ....., 19..... Robert P. Harrison, Registrar

1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 - 1921

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1919, to May 30, 1921, that I last saw h alive on May 30, 1921, and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 9, 1921

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam

(Signed) Edw Talbot, M. D.

5/31, 1921 (Address) 1353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL June 1 - 21

20 UNDERTAKER Abraham Cook ADDRESS 1733 W Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54185

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

8-09 D 54185

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 644 Patapsco ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Garfield

(Residence in Baltimore: No. 644 Patapsco St. Yrs. Mos. Ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Infant

6-DATE OF BIRTH: Dec 19 (Month) (Day), 1919 (Year)

7-AGE: 1 yrs. 5 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Albert Gearie

11-BIRTHPLACE OF FATHER (State or country): N C.

12-MAIDEN NAME OF MOTHER: Jennie Garfield

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Gearie

(Address) 884 Rabnyght St

15-

Filed JUN 1 1921 ROBERT J. KRAUTER REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May 21 (Month) (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 18, 1921, to, May 28 1921, that I saw h.r alive on May 30 1921 and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

W hooping Cough

(Duration) yrs mos ds.

Contributory (SECONDARY) Bronchopneumonia

(Duration) yrs mos 1 ds.

(Signed) J. H. P. Haddock M. D.

May 21 1921 [Address] 1131 N Carrollton

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: June 1 1921

20-UNDERTAKER: David Easton — ADDRESS 916 Park ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.— 1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54186

CERTIFICATE OF DEATH.

120 D 54186

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Douglas

(a) RESIDENCE. No. Unknown St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman 66

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed JUN 1 - 1921 ROBERT J. BRAUTEK Registrar

Burial Permit Oler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1921

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1920, to May 29, 1921

that I last saw him alive on May 29, 1921

and that death occurred, on the date stated above, at 5:55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis
Arterio - sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No especial test.

(Signed) J. Bateman, M. D.

5/30/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 2 1921
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 54187

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 W Cross ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick H Brady

(a) RESIDENCE. NO. 1002 W Cross St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) May 4th 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chicago

PARENTS

10 NAME OF FATHER John Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chicago

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chicago

14 Informant Mrs Brady
(Address) 1002 W Cross St

15 JUN 1 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1921

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to May 29, 1921, that I last saw h alive on .. .. 1921, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stafford Dean, M. D.

, 19 (Address) 600 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 1 1921
20 UNDERTAKER	ADDRESS
John J Fields	1210 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54188 ~ D 54188

D 54188

CERTIFICATE OF DEATH.

30

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 226 N. Pearl ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Tamantina.

(Residence in Baltimore: No. 226 Pearl St St.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Single

6-DATE OF BIRTH. ....., 1.....
(Month) (Day) (Year)

7-AGE. 11 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Custan Tamantina

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Maria Rocco

13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Custan Tamantina

(Address) 226 N. Pearl St

15- Filed JUN 1 - 1921, 191.....

ROBERT J. BRAITER
Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5- 31, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5- 28 1921, to 5-31 1921, that I saw h[illegible] alive on 5-30-1921, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Tubercular
meningitis

(Duration) .....yrs. .....mos. 26 ds.

CONTRIBUTORY.....
(Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) S. Demarco M. D.

6-1-21. (Address) 16 S. Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Cathedral — DATE OF BURIAL. 6/1....., 1921

20-UNDERTAKER. John F Lahey Son — ADDRESS 1518 Light St

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54189

CERTIFICATE OF DEATH.

38 D 54189

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital, Bay View 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Nichols

(a) RESIDENCE. No. 902 Argyle Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ ~~Unknown~~ Rebecca Nichols.

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, M.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 FILED JUN 1 - 1921 19 ROBERT J. BRUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1921, to May 29, 1921, that I last saw him alive on May 29, 1921, and that death occurred, on the date stated above, at 10:15 P.m.

The CAUSE OF DEATH* was as follows: OTN

Urinary infiltration of scrotum & abdominal wall ?
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia ?
(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 5-29-21

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) F. A. Holden, M. D.

5/30/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem	June 2 1921
20 UNDERTAKER David C. Hensley	ADDRESS 578 Dr Bridge

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54190

CERTIFICATE OF DEATH.

1920 D 54190

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 N. Payson ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Frederick Sannebeck

(a) RESIDENCE. No. 615 N. Payson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Blanch Sannebeck

6 DATE OF BIRTH (month, day, and year) Feb 15th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 070

(b) General nature of industry, business, or establishment in which employed (or employer) Penna R.R. Co.

(c) Name of employer Penna R.R. Co

9 BIRTHPLACE (city or town) Baltimore City
(State or country) Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Don't Know
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Don't Know

14 Informant Mary Blanch Sannebeck
(Address) 615 N. Payson St

15 Filed JUN 1 - 1921 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to May 30, 1921, that I last saw h[illegible] alive on May 30, 1921, and that death occurred, on the date stated above, at 935 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lawrence Kahn, M. D.

6/3 1921 (Address) 4027 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
David Bridge Cemetery	June 2nd 1921

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Elmora Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54191

HEALTH DEPARTMENT—CITY OF BALTIMORE

175-001 D 54191

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) St Agnes Hospital ST.: 13 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph E. Simms

(Residence in Baltimore: No. 2509 Linden Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: Nov 29, 1907 (Month) (Day) (Year)

7-AGE, 13 yrs. 6 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Louis Simms

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rebecca Hyman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto

15- Filed JUN 1 - 1921 191.....

ROBERT J. BRUTTER

Burial C. & Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 30, 1921 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to 6 death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture Base of Skull
Auto accident

(Duration) yrs. mos. 2 hrs

CONTRIBUTORY (Secondary) Hemorrhage ext

(Duration) yrs. mos. 2 hrs

(Signed) James M Taylor M. D. (Coroner.)

May 31 1921 (Address) 104 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Washington Rd Howard Co

Former or usual residence 2509 Linden Ave

19-PLACE OF BURIAL OR REMOVAL, Wellwood Brethren Cem

DATE OF BURIAL, JUN 1 - 1921

20-UNDERTAKER F A Weis

ADDRESS 1411 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54192

D 54192

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 678 Haw ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard H. Baker

(Residence in Baltimore: No. 678 Haw St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	col.	married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1850 (Year)

7-AGE,	If LESS than 1 day,
57 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... porter 070
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Henry Baker

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Baker

(Address) 678 Haw st

15- ROBERT J. CRAWFORD

Filed ....., 191... Clerk

JUN 1 - 1921 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 30 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25 1921, to May 30 1921, that I saw h[illegible] alive on May 25 1921, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

..... tuberculosis .....

.....

.....

..... (Duration) about 1½ yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

May 30, 1921 (Address) 2226 Madison Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem.	June 2, 1921

20-UNDERTAKER	ADDRESS
J. H. Trader	1922 W. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 V D 54193

REGISTERED NO.

1-PLACE OF DEATH Boy View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST.: 77 WARD)

2-FULL NAME Arthur Bailey

(a) RESIDENCE. No. 120 Hill ST., WARD.

(Usual place of abode)

Length of residence in city or town where dea... 3a. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
~~1865~~ 56.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Dock

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Boy View Hospital

(Address) Bklyn, Md.

15 Filed JUN 1 - 1921 ROBERT F. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1921, to May 30, 1921

that I last saw h.. alive on May 30, 1921

and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible] Place 7 Dis 7h

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gen. Edwd. Findings

(Signed) H. S. Edwards M. D.

5/31/1921 (Address) Boy View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 2 21
20 UNDERTAKER	ADDRESS
J B Soader	141 N Hill

MARRIAGE should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54194

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54194

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 645 Harvey ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Richard Lohoefer

(a) RESIDENCE. NO. 645 Harvey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sep. 30, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	7	29	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Chas. J. Lohoefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Marguerite Boidyfoo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newport R.I.

14 Informant (Address) Chas. J. Lohoefer 645 Harvey St.

15 Filed JUN 1 - 1921 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1921

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to May 29, 1921.

that I last saw him alive on May 29, 1921.

and that death occurred, on the date stated above, at 6.50 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Valvular Disease of Heart (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) Sidney H. Slagle M. D.

(Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	June 1 1921

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54195

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 54195

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 W Clement ST.: 23 WARD)

2-FULL NAME Jessie R. Ross

(a) RESIDENCE. No. 105 W Clement ST., 23 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alpheus Ross

6 DATE OF BIRTH (month, day, and year) Nov 7 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 17

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co Md
(State or country)

PARENTS

10 NAME OF FATHER John Litchfield

11 BIRTHPLACE OF FATHER (city or town) Howard Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Howard Co Md
(State or country)

14 Informant Alpheus Ross
(Address) 105 W. Clement St.

15 Filed JUN 1 - 1921 ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1921

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1920, to May 30, 1921, that I last saw h.. alive on May 29, 1921, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Carcinoma of uterus

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hyserman, M. D.

5/31, 1921 (Address) 1 E Randall Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	June 1 1921

20 UNDERTAKER Mrs J. E. Evans Son ADDRESS 1428 L.

Charles St.

SHOULD BE CAREFULLY SUPPLIED. AGE ... that it may be properly classified. Exact statement of OCCUPA... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54196

CERTIFICATE OF DEATH.

X 45 D 54196

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hotel Belvedere ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Chappell-

(a) RESIDENCE. No. Hotel Belvedere ST., WARD. San Francisco, Cal.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E. Chappell

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate & Bad Debts.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Kankakee, Ill.

PARENTS

10 NAME OF FATHER A.C. Chappell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Michigan

12 MAIDEN NAME OF MOTHER Angelina Hazelang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Michigan

14 Informant Mrs Margaret Chappell (Address) Hotel Belvedere, Balto

15 Filed JUN 1 - 1921 19 Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1921

17

I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 31, 1921, that I last saw him alive on May 31, 1921, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma left side 7 wks.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? San Francisco, Cal.,

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) C. W. Draper, M. D.

, 19 (Address) 827. N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
San Francisco. Cal.	June 6 1921

20 UNDERTAKER	ADDRESS
John B. Spencer	1325 N Carlton St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54197

CERTIFICATE OF DEATH.

D 54197

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 N. Dallas ST.; 6 WARD)

2-FULL NAME Clarence Diggs

(a) RESIDENCE. No. 100 N. Dallas ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U. S., if of foreign birth? 1 yrs. 10 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) July 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Clarence Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Henrietta Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Robert Williams

(Address): 100 N. Dallas St

15 FILED JUN 1 - 1921 REGISTRAR

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1921, to May 31, 1921, that I last saw h[illegible] alive on May 31, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. M. C. Lothian M. D.

5/31 1921 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Jun 1, 1921
20 UNDERTAKER	ADDRESS
Chas H. Bailey	421 Jefferson St

I. D. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54198

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54198

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 5 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander McLean

(a) RESIDENCE. No. 209 N. Central ave. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian McLean

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

Lives in Balt - 1 year 4 months

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Archie McLean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Caroline Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address) M.T.H.

15 Filed ..... 19 ..... Registrar

JUN 1 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1921, to May 31, 1921, that I last saw him alive on May 31, 1921, and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous pericarditis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. J. Rigney, M. D.

5-31-21. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mccoll. S Carolina	June 1 1921
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1726 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54199 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54199

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Carlisle Ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Webster Bandel.

(a) RESIDENCE. NO. 3210 Carlisle Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Myrtle E. Bandel.

6 DATE OF BIRTH (month, day, and year) Dec 1st 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Thomas & Evans.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Franklin W. Bandel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Alice H. Warner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant James W. Bandel.

(Address) 3210 Carlisle Ave.

15 Filed JUN 1 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1921

17 I HEREBY CERTIFY, That I attended deceased from May 26 1921, to May 30 1921, that I last saw him alive on May 30 1921, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Causing Coma & Hemiplegia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Ch. Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Jefferies Bennett M. D.

6/1, 1921 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 2nd 1921

20 UNDERTAKER William Bosse ADDRESS 1923 N Eden ave Edgewater

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54200 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 54200

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2402 Westwood. Ave. St.: 15 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Fletcher Wright.

(a) RESIDENCE. No. 2402 Westwood Ave. St., Ward.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth S. Wright.

6 DATE OF BIRTH (month, day, and year) March 29th, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 109

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railway & Electric.

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Joseph Wright.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md.

12 MAIDEN NAME OF MOTHER Savannah Gore.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Mrs Elizabeth S. Wright.
(Address) 2402 Westwood Ave.

15 Filed ..... 19 ..... Registrar

N1-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to May 31, 1921, that I last saw him alive on May 31, 1921, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Interstitial).

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Analysis.

(Signed) H. C. Marrel, M. D.

6-1, 1921 (Address) 3311 Abell Ave, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 1921
Stone Chapel Balto Co. Md.	June 2nd
20 UNDERTAKER Bertram Gore	ADDRESS 1923 N. Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54201

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 54201

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick G. Reinhold

(a) RESIDENCE. NO. 1614 Port ST., 8th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	(Married)

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ (Mary C. Reinhold)

6 DATE OF BIRTH (month, day, and year) May 27. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	55		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car cleaner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Samuel Reinhold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lennie Guyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Mary E. Reinhold 1614 Port st

15 Filed JN 1-1921 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1921

17 I HEREBY CERTIFY, That I attended deceased from May 16 1921, to May 31 1921, that I last saw him alive on May 31 1921, and that death occurred, on the date stated above, at 9:40 PM

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Dis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas, M. D.

5-31 1921 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baldwin Cemetery, Steelton, Pa.

DATE OF BURIAL: June 3 1921

20 UNDERTAKER: Zickler & Zickler

ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE should be carefully supplied. AGE at time of death must be stated. See instructions on back of certificates.

D 54202 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54202

CERTIFICATE OF DEATH.

1-PLACE OF DEATH On Stmr. Louise

CITY OF BALTIMORE (No. Foot of West St. St.: 6 Ward) 79

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Banks. (C)

(Residence in Baltimore: No. 516 N. Bond St.

4 ------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored	Married

6-DATE OF BIRTH, May 5th. 1881., 1 (Month) (Day) (Year)

7-AGE, 40 yrs. --- mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman on
(b) General nature of industry, business, or establishment in which employed (or employer)..... Stmr. Louise.

9-BIRTHPLACE, (State or Country), Norfolk Va.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Banks. (C) wife.

(Address) 516 N. Bond St.

15-

Filed JUN 1 - 1921 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 30th. 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Otto Reinhardt M. D. (Coroner.)

May 31., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Parkley Va.	June 2., 1921
20-UNDERTAKER	ADDRESS
Chris. H. Johnson	416 N. Carolin

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54203

CERTIFICATE OF DEATH.

1 120 D 54203

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 N Pearl ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Serio.

(a) RESIDENCE. NO. 320 N. Pearl ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Serio.

6 DATE OF BIRTH (month, day, and year) Dec 8. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Selling & Buying Fruit

(c) Name of employer Benson Mun- Self.

9 BIRTHPLACE (city or town) (State or country) Cefalii Italy.

PARENTS

10 NAME OF FATHER Frank Serio.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cefalii Italy.

12 MAIDEN NAME OF MOTHER Maggie Serio Cefalu

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cefalu Italy

14 Informant Frank Serio. (Address) 633 W Saratoga St.

15 Filed JUN 1 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to May 31, 1921, that I last saw h.. alive on May 31, 1921, and that death occurred, on the date stated above, at 3 P.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Interstitial Et Cirrhosis of Liver

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Hema 8 18 yrs Standing

Did an operation precede death? Yes Date of June 17. 1920

Was there an autopsy? No

What test confirmed diagnosis? Physical. Urinary

(Signed) William H. Wright, M. D.

Dec 1 1921 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 2 1921

20 UNDERTAKER ADDRESS

W M Routson 230 N Greene

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

to be buried by city body at 1003 N. Bath St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54204

CERTIFICATE OF DEATH. D 54204

REGISTERED No. C

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 881 W. Fayette st St.: 18 WARD)

2-FULL NAME Mrs H. Baker-

(Residence in Baltimore: No. 881 W. Fayette st- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Married

6-DATE OF BIRTH, Dont Know (Month), 1 (Day), (Year)

7-AGE, 60 about yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), " " "

12-MAIDEN NAME OF MOTHER " " "

13-BIRTHPLACE OF MOTHER (State or Country), " " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

JUN 1-1921 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 28 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ ~~topsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tbc Hemorrhage Pulmonary
Tuberculosis I
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know
(Duration) yrs. mos. ds.

(Signed) H. B. Jones M. D.
(Coroner.)

June 28, 1921. (Address) 11 W. Saratoga st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, 19....
JOHNS HOPKINS HOSPITAL	JUN 1
20-UNDERTAKER	ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54205 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54205

CERTIFICATE OF DEATH. × 146

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sue M Baylor

(a) RESIDENCE. NO. Bristol, Tenn. ST., WARD. Bristol Tenn.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. B Baylor

6 DATE OF BIRTH (month, day, and year) Oct 11-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 097

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. B Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary French

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUN 1 -1921, 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1921, to June 1, 1921.

that I last saw her alive on June 1, 1921.

and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Brain abscess.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Mastoiditis, Lft.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Tenn.

Did an operation precede death? yes. Date of 5-25-21-5-31-21

Was there an autopsy? yes.

What test confirmed diagnosis? yes.

(Signed) E. L. Bryan, M. D.

(Address) Bristol, Tenn.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bristol, Tenn.	June 2 1921

20 UNDERTAKER John O Mitchell ADDRESS 1201 W Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54206

D 54206 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1224 W. Layette ave ST.; 16 WARD)

2-FULL NAME Lina M. Nelson

(a) RESIDENCE. NO. 1224 W. Lafayette ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Nelson

6 DATE OF BIRTH (month, day, and year) Oct 30. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James A. Nord

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Henry R. Nelson

(Address) 1224 W. Lafayette

15 Filed JUN 1-1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to May 31, 1921, that I last saw h[illegible] alive on May 31, 1921, and that death occurred, on the date stated above, at 10, ...m.

The CAUSE OF DEATH* was as follows:

Progressive Paresis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of X

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John Murray, M. D.

19 24 (Address) 1321 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Charlottesville Va June 3 1921

20 UNDERTAKER — ADDRESS

John O. Mitchell 1201 W. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 54207

CERTIFICATE OF DEATH.

151 D 54207

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3221 Elliott ST.; No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Drager

(a) RESIDENCE. No. 3221 Elliott ST., / WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30 '21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John E Drager

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Rozenski

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Elizabeth Rozenski
(Address) 322 Elliott St.

15 Filed JUN 2 - 1921 ROBERT J. KRAUTER Registrar
Burial Permit 01828

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to June 1, 1921, that I last saw her alive on May 31, 1921, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth (- 6th & 7th month of Pregnancy)

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) general inanition

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) A. W. Wrager, M. D.

June 1, 1921 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Independent Police Lane	June 2nd 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 4038 B. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 54208

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1358 N. Fremont St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Brooks

(Residence in Baltimore: No. 1358 N. Fremont St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	widow

6-DATE OF BIRTH, ... January ..... (Month) ..... (Day), 1850 (Year)

7-AGE	If LESS than 1 day,
70 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Thompson

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Caroline Brown

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Shep

(Address) 1358 N. Fremont Ave

15-

Filed JUN 3 1924 191... ROBERT J. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 31, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Myocarditis, Heart Disease .....

..... (Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... H. D. Hennessy ..... M. D.
(Coroner.)

May 31 1924 (Address) 2507 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	June 2, 1924

20-UNDERTAKER Edw. Ringgold ADDRESS 1463 N. Carey St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 54209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54209

CERTIFICATE OF DEATH.

105

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Russel St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Carpenter

(a) RESIDENCE. NO. 1006 Russel St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mamie Hicks
(Address) 1006 Russel Town

15 Filed ....., 19.... ROBERT J. CHAPPELL Registrar
JUN 2 - 1921 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-13-, 1921, to 5-30-, 1921, that I last saw h[illegible] alive on 5-28-, 1921, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Old Age and
Gastro Intestinal Colitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. P. Boykin, M. D.

, 19 (Address) 1380 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 2 1921
20 UNDERTAKER	ADDRESS
Edw. Quiggold	1463 N Carey

MAGE should be carefully supplied. Accurate information should be stated EXACTLY. Indefinite terms, such as "Laborer," "Housekeeper," etc., should not be used as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54210

CERTIFICATE OF DEATH.

104 D 54210

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1541 Orleans ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Reed

(a) RESIDENCE. No. 1541 Orleans St ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) May 12 1921

7 AGE — Years — Months 19 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER Ralph Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Hattie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ralph Reed
(Address) 1541 Orleans St

15 Filed JUN 2 - 1921 19 ... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31 1921, to June 1, 1921, that I last saw her alive on June 1, 1921, and that death occurred, on the date stated above, at 1 10 a.m.

The CAUSE OF DEATH* was as follows:

Acidosis

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Gastric disturbance

(duration) ... yrs. ... mos. 19 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. J. Baylin M. D.

6/1, 1921 (Address) 210 Lisburn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 3 1921
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	1725 Ashland Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-3-16 — H. P. Co.—1000 Blks.

D 54211 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54211

CERTIFICATE OF DEATH.

REGISTERED NO. 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Mayer

(a) RESIDENCE. No. New York City E. 72 ST., WARD. New York City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? Returned yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11 - 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Romania

PARENTS

10 NAME OF FATHER Jack Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Romania

12 MAIDEN NAME OF MOTHER Rose Weinstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Romania

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUN 2 - 1921 BOARD OF HEALTH Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 - 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15 - 1921, to June 1 - 1921, that I last saw h[illegible] alive on June 1 - 1921, and that death occurred, on the date stated above, at 10 Oc m.

The CAUSE OF DEATH* was as follows:

Brain tumor - glioma left cerebral

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5/19/21

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H B Kuede, M. D.

6/2, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York — DATE OF BURIAL: June 2 1921

20 UNDERTAKER: Jack Lewis — ADDRESS: 1411 E. Balto

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54212

CERTIFICATE OF DEATH.

92 D 54212

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Aliceanna ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wodlig

(a) RESIDENCE. No. 1606 Alicea ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Singl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/5/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ...min.
		5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work " " 00

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Wodlig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Polang

12 MAIDEN NAME OF MOTHER Anna Klimek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Polana

14 Informant Anna Wodlig
(Address) 1606 Al

15 Filed JUN 2 - 1921, 19 ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from 5/30, 1921, to 6/1, 1921, that I last saw h[er] alive on 6/1, 1921, and that death occurred, on the date stated above, at 6:00 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Harry D Wardlaw, M. D.

6/2, 1921 (Address) 1623 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	6/2 1921
UNDERTAKER	ADDRESS
Wm Gaulfowsk & Co	

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54213 D 54213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital 4 × 109 REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eli Fogle

(a) RESIDENCE. No. Holbrook P.O. Owings Mills Md. WARD. Owings Mills
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Fogle.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant N. N. Hauser (Address) Owings Mills Md

15 Filed JUN 2 - 1921 19 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1921, to June 1, 1921, that I last saw h... alive on June 1, 1921, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Same (See note on back)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 26, 1921

Was there an autopsy? No

What test confirmed diagnosis? Harry W. Stair

(Signed) [illegible] M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hardis Chapel Cemetery	June 4 1921
20 UNDERTAKER Jas. R. Weer	ADDRESS Sykesville Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54214

HEALTH DEPARTMENT—CITY OF BALTIMORE

40

D 54214

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (NO. ST.: 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Henry S. Wampole

(a) RESIDENCE. NO. 605 Falls Road Terrace WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unmarried

6 DATE OF BIRTH (month, day, and year) Nov. 19th, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturing Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Henry K. Wampole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Sallie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Miss Wampole (Address) 605 Falls Road Terrace

15 JUN 2 - 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from May 22nd, 1921, to June 1st, 1921, that I last saw h[illegible] alive on June 1st, 1921, and that death occurred, on the date stated above, at 12 45 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.
(Primary focus undiscovered)

(duration) yrs. 2(?) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes. Date of May 23rd, 1921

Was there an autopsy? no.

What test confirmed diagnosis? Operation.

(Signed) J. W. Thimey Jr. M. D.

June 1st 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 3 1921
20 UNDERTAKER	ADDRESS
Henry J. Jenkins Son Co	Eastward Hoe Ballot St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—11. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54215

D 54215

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. St Jos College St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeremiah Co Dahill (Bro. Cajetan)

(a) RESIDENCE. No. Mt St Jos College 20 WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 870

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Bro James Mt St Jos Col.

(Address)

JUN 2-1921 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1921, to June 1, 1921, that I last saw h— alive on May 31, 1921, and that death occurred, on the date stated above at 9a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) W. A. Russell, M. D.

6/1, 1921 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvert Cemetery	June 3 1921
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	763 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 54216

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 623 S Wolfe St ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gruszczynske

(Residence in Baltimore: No. 623 S Wolfe st

St.: 38 yrs., 0 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH May 27, 1871
(Month) (Day) (Year)

7-AGE, 50 yrs. 0 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O H D

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Michael

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Mary —

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Gruszczynski

(Address) 623 S Wolfe St

15 JUN 2 - 1921 Filed....., 191.... [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) D. Kenny Jay M.D.
(Coroner.)

6/2, 1921. (Address) 1 S Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, June 3, 1921.

20-UNDERTAKER W. F. Sadowski ADDRESS 705 S. Ann

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(See affadavit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54217 Minnie

CERTIFICATE OF DEATH.

167 D 54217

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Krakuk

(Residence in Baltimore: No. 1318 McHenry st. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, July (Month) 2 (Day), 1916 (Year)

7-AGE, 4 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. born 700
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto'

PARENTS.

10-NAME OF FATHER, Wm Krakuk

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rose Naia

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Krakuk

(Address) 1318 McHenry st

15- Filed JUN 2 - 1921, 191 ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jun (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severe burns on body

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gen. Debility Pneumonia

(Duration) yrs. mos. ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

Jun 2. 1921 (Address) 117 W. Saratoga st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, JUN 3 1921

20-UNDERTAKER John J. Fields

ADDRESS 1200 W. Lombard

N.B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REG. NO. 1776 ...TIMORE, MD. 7.30 TO 3 P. M. Sundays 9 to 11 a. m. only

℞

6-4-21

The Name on death certificate dated 6-1-21. as Ann K Kirk - should be Minnie K Kirk

T K Gorsuch
Coroner Md.

St. of Maryland }
City of Balto } ss

Sworn & subscribed to before me this 4th day of June 1921

Conrad J. McKenzie
Notary Public

D 54218

D 54218

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Kennedy ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edgar Ferguson

(a) RESIDENCE. No. 2021 Kennedy ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Sallie P. Ferguson

6 DATE OF BIRTH (month, day, and year) March 29th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Manager 086

(b) General nature of industry, business, or establishment in which employed (or employer) Geo E Waters & Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Ferguson

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Morris

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mrs Sallie P. Ferguson
(Address) 2021 Kennedy ave

15 Filed ....., 19.... Robert P. Harrison, Registrar
Burial Permit Clerk

N2—1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from ....., 1916, to June 1, 1921, that I last saw h alive on December, 1920, and that death occurred, on the date stated above, at 12.05 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Herbert Eckenrode, M. D.

June 1921 (Address) 1716 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 4th 1921
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

Before State should be stated EXACTLY. PHYSICIANS should be careful to see that OCCUPATION is properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Green Lane ST.: Clifton Park 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Hooper.

(a) RESIDENCE. No. 3 Green Lane ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 7th 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Victor Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER May Ward.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant V. C. Hooper.

(Address) 3 Green Lane.

15 Filed JUN 2-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to June 1, 1921, that I last saw h... alive on June 1, 1921, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Exhaustion
Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Immigration (Tuber
culosis) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clara Smith, M. D.

, 19 (Address) 47 N. Hanford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 4 1921
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	Hanford & 1734

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54220

CERTIFICATE OF DEATH. 1921

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home of Incurables ST.; 19 WARD)

2-FULL NAME Catherine Steinbach

(a) RESIDENCE. No. 1718 W Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) John H Steinbach

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Eckstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas H Steinbach

(Address) 1718 W Fremont

15 Filed JUN 2-1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to June 1, 1921, that I last saw h alive on May 31, 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows: Nephritis - Uremia

(duration) over 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Gangrene of Leg, (duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? At former residence

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Physical exam. & urine - Physical exam.

(Signed) Wm H Mayo, M. D.

, 19 (Address) Eutaw apts - Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: June 3 1921

20 UNDERTAKER Chas J Tenney & Son ADDRESS 1424 N Howard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54221 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54221

CERTIFICATE OF DEATH.

113

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 E. Mc Culloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A. Dalrymple

(Residence in Baltimore: No. 2125 E. Mc Culloh St.; 23 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	Single

6-DATE OF BIRTH. April 10, 1885
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
36 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cabaret manager
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jas. A. Dalrymple

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Eliza Gross

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... K. Ein R. Trader (wife)

(Address) 2125 E. Mc Culloh St.

15-

Filed..... 1921 Robert P. Harrison, Registrar.

JUN 2 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from early part Feb. 1921, to June 1 1921, that I saw h in alive on June 1 1921, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Bacteric tumor abscess

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) J. F. Schwentker M. D.

June 1, 1921 (Address) 222 6 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Calvert Co. Md	June 4., 1921
20-UNDERTAKER Dukes Wharf	ADDRESS
Kelly B Pye	102 E. Madison St

I. D.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians and others CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54222 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54222

CERTIFICATE OF DEATH.

69

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 641 N. Carey ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Adelaide Wheatley

(a) RESIDENCE. No. 641 N. Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 18-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James A. Wheatley, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md.

12 MAIDEN NAME OF MOTHER Jennie Gubar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md.

14 Informant James A. Wheatley Sr. (Address) 641 N. Carey St.

15 Filed JUN 2 - 1921 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1921, to June 2, 1921, that I last saw her alive on June 1, 1921, and that death occurred, on the date stated above, at 5-45 a. m.

The CAUSE OF DEATH* was as follows:

Epilepsy -
Subject to seizures since
(duration) 19 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) 18 months old.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) A. F. Robinson M. D.

6/2, 1921 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 4 1921
20 UNDERTAKER Geo J. Smith	ADDRESS 1000 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54223

CERTIFICATE OF DEATH.

91 D 54223

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1134 N. Stricker ST., 14 WARD)

2-FULL NAME John D. Evans Jr

(a) RESIDENCE NO. 1134 N. Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 28-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... not any

(b) General nature of industry, business, or establishment in which employed (or employer) ..... for

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John D. Evans

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Georgia Figg

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant John D. Evans Jr
(Address) 1134 N. Stricker St

15 Filed JUN 3 - 1921 ROBERT F. BRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1921, to June 1, 1921, that I last saw him alive on June 1, 1921 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Walter C Bacon M. D.

6/1, 1921 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	June 3 1921

20 UNDERTAKER John O Mitchell ADDRESS 201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54224

CERTIFICATE OF DEATH.

79

D 54224

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 W. Lanvale, ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriet A. Calwell

(Residence in Baltimore: No. 125 W. Lanvale St. St.; 90 yrs., 11 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, June (Month), 26 (Day), 1830 (Year)

7-AGE, 90 yrs. 11 mos. 5 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 600

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Wm. B. Norris

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Amanda A. Norris

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Calwell

(Address) 125 W. Lanvale St.

15- JUN 3 - 1921 ROBERT A. BRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 1st (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1st 1921, to June 1st 1921, that I saw h[illegible] alive on June 1st 1921, and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Senile Myocarditis

(Duration) 5 yrs. [illegible] mos. [illegible] ds.

CONTRIBUTORY (Secondary) –

(Duration) ....yrs....mos....ds.

(Signed) E. L. Flanagan M. D.

6. 2, 1921. (Address) 1515 Park Ave.

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cemetery	June 3, 1921
20-UNDERTAKER	ADDRESS
John C. Mitchell	1201 W. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54225

D 54225

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH 568 St Mary St

CITY OF BALTIMORE: (No. 568 St Mary ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Chase

(a) RESIDENCE. No. 568 St Mary's ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Chase

6 DATE OF BIRTH (month, day, and year) Autumn 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
44	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Louis Lutz

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Georgiana Atkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Anna Chase (Address) 568 St Marys St

15 Filed . 19 ROBERT J. KRAUTER Registrar

JUN 3 - 1921 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15 . 1921 . to May 31 . 1921 . that I last saw him alive on May 30 . 1921 . and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Gustav Goldman . M. D.

19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL June 3 21

20 UNDERTAKER Samuel Hemsley ADDRESS 715 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54226

CERTIFICATE OF DEATH.

78 D 54226

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 N. Mtns St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas Butler

(a) RESIDENCE. No. 503 N Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Barrett

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rosalie Banks
(Address) 1106 Shelby Place

15 Filed JUN 3 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from May 25th, 1921, to June 1st, 1921, that I last saw him alive on June 1st, 1921, and that death occurred, on the date stated above, at 12:20 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis Acute

(duration) yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jas C Carper, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	June 4 1921
20 UNDERTAKER Samuel A. Stanley	ADDRESS 378 W Biddle St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Sharrett

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54227

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54227

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Garrett

(a) RESIDENCE. NO. Maryland Penitentiary ST., WARD. New York.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pike 060 Fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) W. D. Surrey, Warden

15 Filed JUN 3 - 1921 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June - 1 1921

17

I HEREBY CERTIFY, That I attended deceased from February - 28, 1920, to June - 1, 1921, that I last saw him alive on June - 1, 1921, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion,
Influenza, Bronchopneumonia
Emphysema

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. 3 mos. 11 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination & Autopsy

(Signed) William F. Schwarz, M. D.

6/1, 1921 (Address) Maryland Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	June 8 1921

20 UNDERTAKER ADDRESS

Mc-Mech & Fink 1835 N. Paca

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54228

CERTIFICATE OF DEATH.

X 175-001

1-PLACE OF DEATH Biedler's Lellman Hospital

REGISTERED NO. C

CITY OF BALTIMORE (No. 12 ST.: WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Patterson Bassy

(Residence in Baltimore: No. Catonsville's Montrose Ave St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 21 (Day) 1846 (Year)

7-AGE, 75 yrs. — mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George Patterson

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Harriet Thomas

13-BIRTHPLACE OF MOTHER (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George E. Patterson

(Address) Catonsville Md

15- Filed JUN 3 - 1921 191.. ROBERT J. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Tetanus following crushed and lacerated Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Patterson M. D. (Coroner.)

June 3, 1921 (Address) 5632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, June 4, 19 21

20-UNDERTAKER Henry Deaton's Sons Co

ADDRESS Orchard & Collington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54229

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 D 54229

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 S. Ellwood Ave ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie E. Hodges

(a) RESIDENCE. No. 728 S. Ellwood Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George R. Hodges

6 DATE OF BIRTH (month, day, and year) May 6, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	—	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Nelson

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rockie Kitch

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Maryland

14 Informant George R. Hodges (Address) 728 S. Ellwood Ave

15 Filed JUN 3 - 1921 19 ROBERT I. KRAUTER Registrar Burial Permit Oct

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to June 2, 1921, that I last saw her alive on June 1, 1921, and that death occurred, on the date stated above, at 3:10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilghman, M. D.

6/2, 1921 Address 35 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	June 5 1921
20 UNDERTAKER	ADDRESS
A. Sander & Sons	1710 East St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D 54230

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 N. Broadway ST.; 8 WARD)

2-FULL NAME Elizabeth Ann. Phillips

(a) RESIDENCE. No. 1608 N. Broadway ST., WARD,
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Phillips

6 DATE OF BIRTH (month, day, and year) Aug. 31, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife ppd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Grenville

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Elizabeth A. Johns
(Address) 608 N. Broadway

15 Filed JUN 3 - 1921 ROBERT I. SLAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1921

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to June 2, 1921, that I last saw her alive on June 2, 1921, and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis from cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? Died of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual clinical

(Signed) S. Nevitt M. D.

June 3 1921 (Address) 865 W. 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	June 4 1921
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Eut St.

WHITE PERSONS, WITH FAMILIAR NAMES, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 54231 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54231

CERTIFICATE OF DEATH. 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210-W-Chase St ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Lewis

(a) RESIDENCE NO. 210 W Chase St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Maryland

PARENTS

10 NAME OF FATHER William Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann Mason Swift

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Charles Louis Brother

(Address) 210 W Chase St

15 Filed JUN 3 - 1921 ROBERT A KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1921

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1921, to May 31, 1921, that I last saw her alive on May 31, 1921 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Carcinoma of Breast.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Carcinoma + Blood Poisons (duration) yrs. 7 mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D. H. Kennard M. D.

6-1, 1921 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery

DATE OF BURIAL June 3 1921

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1325 Eshland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54232

D 54232

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Eutaw St.; not known WARD) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Bell

(Residence in Baltimore: No. 14 Eutaw St. not known St.; 55 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	Single

6-DATE OF BIRTH, Dec. (Month) 22 (Day), 1917 (Year)

7-AGE, 3 yrs. 5 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): home

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Richard Bell

11-BIRTHPLACE OF FATHER (State or Country), md.

12-MAIDEN NAME OF MOTHER Katie Bell

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Bell

(Address) Not known

15- Filed JUN 3 - 1921 ROBERT J. BRAUNE Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 28 1921, to June 1 1921, that I saw h-im alive on May 31 1921, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

MTV

Bronchopneumonia

(Duration) No. yrs. No. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Intestinal T

(Duration) No. yrs. No. mos. 2 ds.

(Signed) Raymond S. Shaw M. D.

June 2, 1921. (Address) Gaithersburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery | DATE OF BURIAL, June 3, 1921

20-UNDERTAKER Wm. Scott Hooper | ADDRESS 406 W. Lanvale St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54233

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2315 Stockton ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hopkins

(a) RESIDENCE. No. 2315 Stockton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Hopkins

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Irene Williams
(Address) 706 Carlette St

15 JUN 3 - 1921 [illegible] Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1921, to June 1, 1921, that I last saw h[illegible] alive on May 31, 1921, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Prostatis and Pyelytis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Kester, M. D.

, 19 (Address) 2008 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	June 3 1921

20 UNDERTAKER Edw. Ruggold ADDRESS 1463 Carey St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54234

Spec. 36-9-5-21 2M 1000 Bks.

D 54234

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 Hooker ST. 14 WARD)

2-FULL NAME Catherine Henry

(a) RESIDENCE. No. 122 Hooker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph M Henry

6 DATE OF BIRTH (month, day, and year) 2-28-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Christian

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Polly Henry

(Address) 122 Hooker St

15 JUN 8-1921 ROBERT J. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 - 1921

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1921, to June 2, 1921, that I last saw her alive on June 1, 1921, and that death occurred, on the date stated above, at 1. a - m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

Cardiac Insufficiency (duration) 7 yrs. 4 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frances A. Carpenter D.

, 19 (Address) 201 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Woodmere	June 4 1921
20 UNDERTAKER	ADDRESS
Wm. Lee Fahey & Son	1827 W North Ave

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 54235 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 169 D 54235

1-PLACE OF DEATH Drowned off River View. REGISTERED NO. C

CITY OF BALTIMORE (No. Found floating off 5 Locust St. Point. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Howard.

(Residence in Baltimore: No. 725 W. Lexington St. St.; -- yrs., 6 mos. --- ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, November 6th. 1901, 1 (Month) (Day) (Year)

7-AGE. 20 yrs. 6 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seaman, O.S.
(b) General nature of industry, business, or establishment in which employed (or employer)..... S/S Auburn.

9-BIRTHPLACE, (State or Country), Excelsior, Minn.

PARENTS.

10-NAME OF FATHER, Edward E. Howard.

11-BIRTHPLACE OF FATHER (State or Country). Excelsior, Minn.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Gaskill.

(Address) 725 W. Lexington St.

15- JUN 3 - 1921 ROBERT J KRAUSE
Filed....., 191... Burial Permit Clerk
Reg. Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Drowned May 25, 1921.
Body found June 2, 1921. 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned, while in bathing.

(Duration)...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration)...yrs...mos...ds.

(Signed) Otto M. Rosenhardt M. D. (Coroner.)

June 2, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	JUN. 3, 1921
20-UNDERTAKER John F. Denny	ADDRESS 715 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54236

CERTIFICATE OF DEATH.

79 D 54236

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Larkin.

(a) RESIDENCE. NO. Preston Near Pat ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Larkin.

6 DATE OF BIRTH (month, day, and year) May 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McLaughlin.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Anna Mahon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Sister Florence

15 Filed JUN 8 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from No Record, 19 , to , 19 ,

that I last saw her alive on May 29, 1921,

and that death occurred, on the date stated above, at 1 45 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Allraner, M. D.

June 2, 1921 (Address) 1133 Valley st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	June 4 1921

20 UNDERTAKER ADDRESS

J. C. Wiedefeld 917 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54237 HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 54237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 E Fort Ave St. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Cooper

(a) RESIDENCE. No. 128 E Fort Ave St. 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Cooper

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Henry Lightner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ann Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Jos. Cooper

(Address) 108 E Fort Ave

15 Filed JUN 3 — 1921

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/1 1921

17 I HEREBY CERTIFY, That I attended deceased from May 2nd, 1920, to June 1st, 1921, that I last saw her alive on June 1st, 1921, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia. (Apoplexy)

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (secondary) Arteriosclerosis & High Blood Pressure (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B Kolb, M. D.

(Address) 1703 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	6/4 1921
20 UNDERTAKER J. J. Talbert & Sons	ADDRESS 1812 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54238

CERTIFICATE OF DEATH.

20 D 54238

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3125 Dillon ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard H. H. Johns.

(a) RESIDENCE. No. 3125 Dillon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Johns.

6 DATE OF BIRTH (month, day, and year) April 16-1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist D26

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Copper + Smelting Co. Canton

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Urias Johns.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Loding

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Margaret Johns (Address) 3125 Dillon St.

15 Filed JUN 3, 1921 [illegible] COKER & KAUFFER Registrar Bodies Issued Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1921

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1921 to June 2, 1921, that I last saw him alive on June 2, 1921, and that death occurred, on the date stated above, at 5.15 A m.

The CAUSE OF DEATH* was as follows:

Undetermined

Septicaemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pleural Effusion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Durant B Fetlow M. D.

6/2, 1921 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	June 6 1921
20 UNDERTAKER	ADDRESS
Zikler + Zikler	1739 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H V D 54239

REGISTERED No. C.....

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. Lafayette Ave + Isbell ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Mary E Parlett

(Residence in Baltimore: No. 114 Woodlawn Rd Roland Pk St.; 69 yrs., 2 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 20, 1852
(Month) (Day) (Year)

7-AGE, 69 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of indnstry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Baltimore Co Md

PARENTS.

10-NAME OF FATHER, Benj. F. Parlett

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Mary E Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Agatha Maloney (Sister)

(Address) Atlantic City N J

15- Filed JUN 3 - 1921 Burial Permit Issued ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 27 1921, to June 3 1921, that I saw h[illegible] alive on " 3 1921, and that death occurred, on the date stated above, at 4.55 A m.

The CAUSE OF DEATH* was as follows: Heart failure

Myocardial Insufficiency

Renal Metastases

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Carcinoma - Abdominal

(Duration) ....yrs....mos....ds.

(Signed) Frank deVerling Lo M. D.

June 3..., 1921. (Address) Women's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State 69 yrs. 2 mos. 14 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 114 Woodlawn Road

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, June 6 1921

20-UNDERTAKER, [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54240

CERTIFICATE OF DEATH.

104 D 54240

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 3rd Ave East Brooklyn St.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Becker

(Residence in Baltimore: No. 37 3rd Ave - East Brooklyn St.: ..... yrs., 15 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March (Month) 3 (Day), 1920 (Year)

7-AGE, 1 yrs. 3 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Otto Becker

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Zofia Kozlowski

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto Becker

(Address) 37 3rd ave East Brooklyn

15-

Filed JUN 3 - 1921, 191.....

[illegible] Burial Permit [illegible] Register

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 31 1921, to June 2 1921, that I saw him alive on June 1 1921, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Convulsions 6 hours

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leon D. Stolzy M. D.

June 2 1921 (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus

DATE OF BURIAL June 3, 1921

UNDERTAKER William Gallagher

ADDRESS 668 Caroline

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54241

CERTIFICATE OF DEATH.

175-001

D 54241
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Neal

(Residence in Baltimore: No. 1807 Druid Hill Ave, St.; 15 yrs., 11 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, June 24, 1905
(Month) (Day) (Year)

7-AGE, 15 yrs. 11 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md,

PARENTS.

10-NAME OF FATHER, Abraham Neal

11-BIRTHPLACE OF FATHER (State or Country), Reedsville, N. C,

12-MAIDEN NAME OF MOTHER Ella Harper

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Neal

(Address) 1809 Druid Hill Ave.

15-

Filed JUN 3 - 1921 ROBERT J. KRAUTH
Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (Fall) 2 hrs.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) automobile accident
(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

June 3 1921 (Address) 2802 Eutaw Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, June 3 1921

20-UNDERTAKER Samuel Hennessy ADDRESS 518 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54242 (8520)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54242

CERTIFICATE OF DEATH.

117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Magness

(a) RESIDENCE. NO. 945 Bower-ave ST., Balto Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of w-m H magness Same address.

6 DATE OF BIRTH (month, day, and year) 1865 Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James McGrath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Record.

15 Filed JUN 3 - 1921 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 — 1921

17 I HEREBY CERTIFY, That I attended deceased from May 31 — 1921, to June 2 — 1921, that I last saw her alive on June 2 — 1921, and that death occurred, on the date stated above, at 8 45 a m.

The CAUSE OF DEATH* was as follows:

General peritonitis —

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/31/21

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) H. H. Kretschmer, M. D.

6/2, 1921 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 6 1921
20 UNDERTAKER Henry Hoeck Son	ADDRESS 1301 E Eager st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pneumococcus
Peritonitis. Type
not known

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54243

CERTIFICATE OF DEATH.

138 D 54243

1-PLACE OF DEATH Wise Emergency Hosp. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 6 ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gerald Linn Percy

(Residence in Baltimore: No. 1406 E Biddle St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White.	Single

6-DATE OF BIRTH, May 25, 1896
(Month) (Day) (Year)

7-AGE, 25 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None (at)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Robert Percy

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Emma T. Fogarty

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma T. Percy

(Address) 1406 E Biddle St

15-

Filed ....., 191.....

ROBERT J. KRAUTH
Registrar.

Burial Permit Issued

JUN 3 - 1921

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3rd, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2nd 1921, to June 3rd 1921, that I saw h.. alive on June 3rd 191.., and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) ..... mos. ..... ds.

(Signed) Dan'l and Duncan Maclean M. D.

June 3, 1921 (Address) 1037 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemy	June 6., 1921.
20-UNDERTAKER Henry Hoeck Son	ADDRESS 1311 E Eager St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54244

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1268 Rennert ave St. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Marsh Jr

(a) RESIDENCE. NO. 1268 Rennert ave ST.... WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. mos. 1½ ds. How long in U. S., if of foreign birth? ... yrs. mos. 1½ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) June 2-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1½	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Walter Marsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Myrtle Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Walter Marsh (Address) 1268 Rennert ave

15 Filed JUN 3 1921 19... ROBERT J. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1921

17

I HEREBY CERTIFY, That I attended deceased from June 2 1921, to June 3 1921, that I last saw h[illegible] alive on June 2 1921, and that death occurred, on the date stated above, at — 7.30a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 5½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? ———

(Signed) O. Mitchell M. D.

June 3 1921 (Address) 1279 Hillman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	6/3 1921
20 UNDERTAKER	ADDRESS
L. Few McCully	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1900 Bks.

D 54245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 54245

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 213 Inlors ally ST.; (WARD) 4

2-FULL NAME Ernest Jarmay

(a) RESIDENCE. No. 213 Inlors ally ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colod	marrid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	yrs		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Lab

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country) Prince Georges Co

PARENTS

10 NAME OF FATHER My Jarmay

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country) Princefrorge Cy

12 MAIDEN NAME OF MOTHER Maria Mullins

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country) Prince Georges Co

14 Informant Mrs E Jarmay
(Address) 213 Inlors alley

15 Filed JUN 3 - 1921 ROBERT P. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2 1921

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1921, to Jan. 1, 1921, that I last saw h.m alive on Jan 31, 1921, and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W K Jamison, M. D.

6-2-1921 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 5th 1921
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Same

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54246

CERTIFICATE OF DEATH.

D 54246

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 McCulloh St.; 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Carroll

(Residence in Baltimore: No. 1617 McCulloh St.; 16 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 23, 1893, (Month) (Day) (Year)

7-AGE, 28 yrs. 4 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Foundry 41
(b) General nature of industry, business, or establishment in which employed (or employer). Iron Co.

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Carroll

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Carroll

(Address) 793 Forrest St

15- Filed JUN 3 - 1921, 191.... ROBERT J. KRAUTER Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1 St, 1921. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16th 1921, to June 1st 1921, that I saw h[illegible] alive on June 1st 1921, and that death occurred, on the date stated above at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Pyaemia from Tonsilitis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Jan Ellis M. D.

June 4, 1921 (Address) 924 Mad Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem

DATE OF BURIAL, June 5, 1921

20-UNDERTAKER Daniel Easton

ADDRESS 916 Dallas

D 54247 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54247

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 123 Welcome Alley. ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Fisher. (C)

(Residence in Baltimore: No. 123 Welcome Alley.

60 ---------
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Widower.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1 (Year)

7-AGE, 60 yrs. ---------- mos. ---------- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Harris, (C)

(Address) 123 Welcome Alley.

15- Robert P. Harrison,

Filed JUN 8 1921, 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27th. 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

June 2., 1921 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 19....

20-UNDERTAKER ADDRESS

Commissioner Health.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

NOTICE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54248

CERTIFICATE OF DEATH.

40 D 54248

1-PLACE OF DEATH St Agnes Hosp. REGISTERED NO.

CITY OF BALTIMORE: (NO. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Hannah Rodgers

(a) RESIDENCE. NO. 820 Woodly ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	M

5a If married, widowed, or divorced (or) WIFE of Terence Rodgers

6 DATE OF BIRTH (month, day, and year) January 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Reynard Barr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christiana

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Rodgers

(Address) 1521 Ramsay St

15 Filed Robert P. Harrison, Registrar

NS-1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1 1921

17 I HEREBY CERTIFY, That I attended deceased from 5-10, 1921, to 6-1, 1921, that I last saw h.. alive on 6-1, 1921, and that death occurred, on the date stated above, at 10:30P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach involving gall bladder + pancreas (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-17-21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W McCrea, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	6/6/21

20 UNDERTAKER George A Fahey ADDRESS Fulton & Fayette

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54249 — CERTIFICATE OF DEATH. — X 79 D 54249

1-PLACE OF DEATH Union Memorial Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John S. Rogers

(a) RESIDENCE. NO. Adamstown, Maryland. WARD. • Adamstown Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs John S. Rogers.

6 DATE OF BIRTH (month, day, and year) December 5th 1860.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Architect. gb

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Mr. John S. Rogers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Virginia Seafe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Mrs. F. Rogers (Address) 16 South St

15 Filed June 3-1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from May 17th, 1921, to June 3rd, 1921, that I last saw him alive on June 3rd, 1921, and that death occurred, on the date stated above, at 1 05 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma; Emphysema.

(duration) 12 yrs. mos. (6 yrs) ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency, decompensation (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical course.

(Signed) J. W. Heuisler, M. D.

June 3rd, 1921 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Frederick Md June 6 1921

20 UNDERTAKER — ADDRESS

John O. Mitchell 1201 W. Fayette St

CAUSE OF DEATH. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54250

120 D 54250

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3617 Forest Park Ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M March

(a) RESIDENCE. No. 3617 Forest Park Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June 21 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James March

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah E Grouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oxford Md

14 Informant Mrs W H Price

(Address) 3617 Forest Park Ave

15 Filed JUN 3 - 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1921

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1921, to June 2, 1921, that I last saw her alive on June 2, 1921, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Nephritis, Interstitial. Chr

.....(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Analysis & History.

(Signed) Wm A. Duvall, M. D.

, 19 (Address) 3573 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	June 1921
20 UNDERTAKER	ADDRESS
Wm J Freeman & Son	Norwood

CAUSE OF DEATH ... TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54251 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54251

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 333 Stinson ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Moore

(a) RESIDENCE. NO. 333 Stinson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amalie Moore

6 DATE OF BIRTH (month, day, and year) Sept 14 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholster

(b) General nature of industry, business, or establishment in which employed (or employer) Goldstrom Bros

(c) Name of employer Goldstrom Bros

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER A. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Amalie Moore

(Address) 333 Stinson St

15 Filed JUN 3 - 1921 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1921, to June 3, 1921, that I last saw h[illegible] alive on June 2, 1921, and that death occurred, on the date stated above, at 7 15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Norbert Gutsch, M. D.

6/3/21, 19 (Address) 2151 Eutaw ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemy	June 6 1921
20 UNDERTAKER Jos Foerdans & Son	ADDRESS 217 S. Bka

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D 54252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1509 Mosher ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena A White

(Residence in Baltimore: No. 1509 Mosher St. St.; 2 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 13 (Day), 1902 (Year)

7-AGE, 18 yrs. 11 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Chas A White

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Martha Banks

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Martha White

(Address) 1509 Mosher St.

15-

Filed..... Robert P. Harrison, Registrar.

JUN 4 - 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20 1921, to June 2 1921, that I saw h[illegible] alive on June 2 1921, and that death occurred, on the date stated above, at 2.45 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ....yrs. 5 mos. .....ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) ....yrs. 1 mos. .....ds.

(Signed) J. H. Hawkins M. D.

June 3., 1921 (Address) 1312 Druid Hill Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, June 5., 1921

20-UNDERTAKER John H. Toadvine — ADDRESS 1 X 2 W Niel St

Cross out words not important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54253 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54253

37

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Watson

(a) RESIDENCE. No. 926 Druid Hil Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital

15 Filed Robert P. Harrison, Registrar

JN4 1921 Burial Permit Clerk.

CAUSE OF DEATH ... TION is very important. See instructions on ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1921

17

I HEREBY CERTIFY, That I attended deceased from October 22, 1920, to June 2, 1921, that I last saw him alive on June 2, 1921, and that death occurred, on the date stated above, at 1:40 P m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency, cystitis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Wasserman.

(Signed) B Herman, M. D.

6/2/ 1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 4 1921

20 UNDERTAKER John H Toadvine ADDRESS 142 W Fitzel St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54254

79-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Buckman.

(a) RESIDENCE. No. 2003 Keyser St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 070

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER George Button

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) born in Va

14

Informant Josephine Henderson

(Address) 219 Chatham St

JUN 4 1921 Filed ..... 19.....

Robert F. Harrison, Registrar

By ..... Permit Clerk.

'TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1921.

17

I HEREBY CERTIFY, That I attended deceased from May 26th, 1921, to June 3rd, 1921, that I last saw her alive on June 3rd, 1921, and that death occurred, on the date stated above, at 2.00 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy and Physical examination

(Signed) E. C. Traum M. D.

June 3, 1924 (Address) St. Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	June 6 1921
20 UNDERTAKER	ADDRESS
Jno R A Elliott	1723 Holland St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54255 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 54255

CERTIFICATE OF DEATH.

151

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 Powell Ave ST.: Raspeburg 26 WARD)

2-FULL NAME Zaithnik Infant

(a) RESIDENCE. NO. 36 Powell Ave ST.: Raspeburg WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 3/4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1st 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1 3/4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John Zaithnik

11 BIRTHPLACE OF FATHER (city or town) Hungary
(State or country)

12 MAIDEN NAME OF MOTHER Mary Herold

13 BIRTHPLACE OF MOTHER (city or town) Hungary
(State or country)

14 Informant Mr. John Zaithnik
(Address) 36 Powell Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar
Burial Permit Clerk.

N4-1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1921, to June 3rd, 1921,
that I last saw h.. alive on June 2, 1921,
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:

Premature birth

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John Hamill M. D.

, 19 (Address) 1430 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cemetery	June 4 1921
20 UNDERTAKER	ADDRESS
Fred'k Lassahn & Sons	Fullerton Md.

CAUSE OF DEATH: See instructions on back. ATTENTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54256 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D 54256

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1023 Bush St — St. 21 Ward)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Wonder.

(a) RESIDENCE. No. 1023 Bush St — St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female.	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Robert Wonder.

6 DATE OF BIRTH (month, day, and year) March 20-1889.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
32.	2.	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) — — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Tubbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margaret Fogarty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr Robert Wonder. (Address) 1023 Bush St —

15 Filed , 19 Robert P. Harrison, Registrar

N4 - 1921 Burial Permit Clerk.

CAUSE OF DEATH ... TION is very important. See instructions on back of ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1921, to June 4, 1921, that I last saw h.. alive on May 31, 1921, and that death occurred, on the date stated above, at 6 2 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular Left Lung.
Influenza

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

2-6, 1921 (Address) 602 Columbia —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 4th, 1921
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hollins St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54257 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54257

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 607 E 27th — ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George N. Murgatroyd

(a) RESIDENCE. No. 607 E 27 st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Murgatroyd

6 DATE OF BIRTH (month) February 22nd 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Poultry Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) " 045

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Murgatroyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Alice Senior

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mary E. Murgatroyd (Address) 607 E. 27th St

15 Filed JUN 4 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) June (day) 1st 1921

17 I HEREBY CERTIFY, That I attended deceased from May 28 1921, to June 2 1921, that I last saw h[illegible] alive on June 1 1921, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 0

Did an operation precede death? no Date of 0

Was there an autopsy? no

What test confirmed diagnosis? 0

(Signed) E B Freeman, M. D.

, 19 (Address) 412 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 6 1921

20 UNDERTAKER H. C. Waedefeld ADDRESS 914 Greenmount

TION is very important. See instructions on

D 54258 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54258

CERTIFICATE OF DEATH.

REGISTERED No. C 182

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St. Joseph Hospital ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Leursson

(Residence in Baltimore: No. Brendon Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March 25 (Month) 1896 (Day), 1 (Year)

7-AGE 25 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) 034

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Chas. H. Leursson

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER C. Lieber

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. H. Leursson

(Address) Grendon Ave Gardenville

15- Robert P. Harrison,

Filed....., 191.... Burial Permit Clerk, Registrar.

JUN 4 1921

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 1 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by Pistol

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. F. Luckey M. D.
(Coroner) H. E. Colvin
6-4, 192.. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Immanuel DATE OF BURIAL, June 5, 192.

20-UNDERTAKER H. Heimann ADDRESS 32 S. Broadway

13.—Every item of DEATH in plain terms. Be sure to give CAUSE OF DEATH in plain terms. It may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54259 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54259

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 S. Eutaw St.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Jane Henderson

(a) RESIDENCE. No. 516 S. Eutaw St., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Robert Henderson

6 DATE OF BIRTH (month, day, and year) March 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Capt. John W. Erodwell

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Emma Jane Carney.

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant George E. Henderson

(Address) 516 S. Eutaw St.

15 Filed 1921 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1921

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to May 31, 1921, that I last saw her alive on May 31, 1921, and that death occurred, on the date stated above, at 8 10 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Physical Signs

(Signed) C. S. Beer, M. D.

6/2/21 (Address) 408 E Pat Pk Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	June 4th 1921
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, as fully as possible. See instructions on back of certificate. TION is very important.

N4

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54260

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 54260

150

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816-E. Federal ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Harris

(a) RESIDENCE. NO. 1816-E. Federal ST., WARD. 8

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/24/1921

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	—	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None—000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John B. Harris

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Theone E. McCarter

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant John B. Harris
(Address) 1816-E. Federal

15 Filed JUN 4 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1921, to June 2, 1921, that I last saw h.. alive on June 2, 1921, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Spina Bifida

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Feasby M. D.

(Address) 1223 N. Carolina st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 6/4/21 19

20 UNDERTAKER Geo. J. Ruth ADDRESS 1725 Harford ave

CAUSE OF DEATH in plain terms, and that is the back of certificates. See instructions on back of TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54261 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D 54261

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 Wilkins St. ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha Holzer.

(a) RESIDENCE. NO. 10 Wilkins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Holzer.

6 DATE OF BIRTH (month, day, and year) May 16th, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	----	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Henry Grein.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John H. Holzer.
(Address) 10 Wilkins St.

15 Filed ... 19... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from May 12 1921, to June 2, 1921.
that I last saw h er alive on June 1, 1921
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. H. Burkert M. D.

6/3, 1921 (Address) 1100 W Lafayette

*State the Disease Causing Death, or (in deaths from) Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery.	June 6th 1921

20 UNDERTAKER Bertram Cook ADDRESS 1723 W Lafayette Ave

CAUSE OF DEATH ... See instructions on back of TION is very important.

4 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54262

HEALTH DEPARTMENT—CITY OF BALTIMORE D 54262

CERTIFICATE OF DEATH.

REGISTERED NO. 1202

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. New City Hospital, Bay View WARD 26)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah MacClain

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

Filed JUN 4 - 1921 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1918, to June 1, 1921, that I last saw her alive on June 1, 1921, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteria-sclerosis.
Cerebral hemorrhage.
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No special test.

(Signed) W. H. Freeman M. D.

6/2/1921 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL JUN 4 - 1921

20 UNDERTAKER

ADDRESS

Commissioner Health.

CAUSE OF DEATH to be plainly written. See instructions on back of Certificate. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54263

CERTIFICATE OF DEATH.

X 43

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Wynnoke ave. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelia M. Mitchell

(a) RESIDENCE. No. 609 Wynnoke ave ST., WARD Port Deposit Md.

(Usual place of abode) (If nonresident give city or town and State).

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Clinton White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D. C.

12 MAIDEN NAME OF MOTHER Barbara Dennison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Medna M. Smith

(Address) 609 Wynnoke ave.

15 Filed 6/4 1921 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3/21 1921

17 I HEREBY CERTIFY, That I attended deceased frum Apr 6, 1921, to June 3, 1921, that I last saw her alive on 6/3, 1921, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Left Breast.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. W. Ross M. D.

6/4, 1921 (Address) 2028 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Port Deposit Md.

DATE OF BURIAL June 6 1921

20 UNDERTAKER Wm. Cook

ADDRESS 502 E. Nath

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

N4 - 1921

Spec.—6-9-19—H. P. Co.—1000 Bks.

54264 HEALTH DEPARTMENT—CITY OF BALTIMORE 54264

D 54264

CERTIFICATE OF DEATH. 104 D 54264

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Dunn

(a) RESIDENCE. NO. St. Vincents Inf Asylum WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11 Months			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant (Address) Mrs. Lillian Dunn 1609 Aisquith St.

15 Filed JUN 5 - 1921 ROBERT J. BRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4 1921

17 I HEREBY CERTIFY, That I attended deceased from 6-1-21, 19..., to 6-4, 1921, that I last saw him alive on 6-4, 1921, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm McCraig, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St Peters June 4 1921

20 UNDERTAKER — ADDRESS

Martin Lahey & Sons 1807 W Nth Ave

CAUSE OF DEATH in plain terms, as per instructions on back of certificate. TION is very important. See instructions on back of certificate.

Louise Myers

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54265

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 Richmond ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Myers

(a) RESIDENCE. No. 221 Richmond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 13 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		X	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(h) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Elton Myers

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Eva Jackson

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Elton Myers
(Address) 221 Richmond

15 Filed JUN 5 1921 19 ROBERT J. BRUTLE Registrar

Burial Permit Issued

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1921

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 3, 1921, that I last saw her alive on June 3, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Edema Pneumonia

(duration) — yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Emil Wagner, M. D.

, 19 (Address) 1756 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 5 1921

20 UNDERTAKER Samuel L. Hensley ADDRESS 708 Bdle

Spec.—8-24-14—M. & T.—2000 Bks.

Fortie

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54266

D 54266

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 940 Mason ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lloyd L. Fortie

(Residence in Baltimore: No. 940 Mason St.; 40 yrs., 2 mos. 7 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, March 26, 1881
(Month) (Day) (Year)

7-AGE, 40 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fish Packer
(b) General nature of industry, business, or establishment in which employed (or employer): Fish Packing

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Lloyd Fortie

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Cecelia Agnella

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cecelia Fortie

(Address) 735 N. Bethany Pl.

15- Filed JUN 5 - 1921, 191.. ROBERT J. KRAUTH, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1921.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1921, to June 2d 1921,
that I saw him alive on June 2d 1921,
and that death occurred, on the date stated above, at 11.35 p. m.

The CAUSE OF DEATH* was as follows:

1.....
2.....
3.....

Pulmonary Tuberculosis (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastritis & Cardiac Weakness (Duration) 7 yrs. mos. 18 ds.

(Signed) Edward Gill Mackenzie M. D.

June 3, 1921. (Address) 1329 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, June 5, 1921

20-UNDERTAKER Thomas A. Newell ADDRESS 578 Broadway

CAUSE OF DEATH. See instructions on back of certificate. Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

40 V D 54267

REGISTERED NO. D 54267

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 143 S. Central ave ST.: 3 WARD)

2-FULL NAME William Posner

(a) RESIDENCE. No. 143 S. Centralave ST.. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Yetta Posner
6 DATE OF BIRTH (month, day, and year) Years: 59 Months: — Days: — If LESS than 1 day, ... hrs. or ... min.: —
7 AGE
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Book Binder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country): Russia
PARENTS
10 NAME OF FATHER: Michael Posner
11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia
12 MAIDEN NAME OF MOTHER: Mary
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia
14 Informant (Address)
15 Filed JUN 5 1921 Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1921
17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1921 to June 4th 1921,
that I last saw him alive on June 4th 1921,
and that death occurred, on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:
Cancer Stomach
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Hypertension (duration) yrs. 3 mos. ds.
18 Where was disease contracted if not at place of death? No Date of
Did an operation precede death? No
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) M. D.
6/4 1921 (Address) 210 N Futon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Levy Rosedale
DATE OF BURIAL: June 5 1921
20 UNDERTAKER: Jack Lewis
ADDRESS: 1411 E Balto

CAUSE OF DEATH INSTRUCTION is very important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54268

CERTIFICATE OF DEATH.

64 D 54268

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Eutaw Pl. Wilson St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Dealhaun

(Residence in Baltimore: No. The Marlborough apts St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 5 (Day), 1867 (Year)

7-AGE, 54 yrs. 1 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Vice President
(b) General nature of industry, business, or establishment in which employed (or employer): Cisco Mfg Co

9-BIRTHPLACE, (State or Country) Alexandria Va

PARENTS.

10-NAME OF FATHER, Simon Dealhaun

11-BIRTHPLACE OF FATHER (State or Country), Bavaria

12-MAIDEN NAME OF MOTHER Lizzie Schwarz

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred J. Dealhaun

(Address) Tioga Norwood Cor. Howard Pl.

15-

Filed JUN 5 1924 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~May~~ June (Month) 3rd (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 31 1924, to June 3 1924, that I saw h[illegible] alive on June 3 1924, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) Louis P. Hamburger M. D.

June 4, 1924 (Address) 1 W. Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew cem

DATE OF BURIAL, June 6 1924

20-UNDERTAKER J. Ahrens & Co

ADDRESS 1611 Madison

IMPORTANT. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54269
148508

HEALTH DEPARTMENT—CITY OF BALTIMORE

102D 54269

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHARLES B. KENNEDY

(a) RESIDENCE. NO. 5208 PARK HEIGHTS AVE. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	MARRIED

5a If married, widowed, or divorced
HUSBAND of (~~or WIFE of~~) MARTHA A. KENNEDY

6 DATE OF BIRTH (month, day, and year) Sept 17-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work RETIRED GROCER
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Indiana Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUN 5 - 1921 ROBERT S. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUNE 2 1921

17 I HEREBY CERTIFY, That I attended deceased from MAY 31 1921, to JUNE 2 1921, that I last saw him alive on JUNE 2 1921, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:
CEREBRAL THROMBOSIS
PEPTIC ULCER

(duration) — yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. K. Traser, M. D.

6-2, 1921 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
DRUIDRIDGE CEM	6/6/21 19
20 UNDERTAKER ROBERT BROOKS SON	ADDRESS CALHOUN HOLLINS ST

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54270

CERTIFICATE OF DEATH.

91 D 54270

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. West End Maternity ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Shabitt

(a) RESIDENCE NO. 10 st Morrell Park ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Schabitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Dongella Sutfell 6/4/1921

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sutts Pa

14 Informant Edna Shabitt. (Address) 10 st Morrell Park.

15 Filed JUN 5 - 1921 ROBERT J. BRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1921, to June 4, 1921, that I last saw her alive on June 4, 1921, and that death occurred, on the date stated above, at 1030 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter E. Cox, M. D.

(Address) 541 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	6-6 1921
20 UNDERTAKER	ADDRESS 17
Robert Brooks & Son	S Calhoun st

CAUSE OF DEATH. See instructions on this page. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

148373 D 54271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

132 D 54271

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Callie Hopewell

(a) RESIDENCE. NO. 1404 North Gilmore St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Brown (Friend) 610 Warney St.

6 DATE OF BIRTH (month, day, and year) April 15, 1886.

7 AGE: Years 35 Months 1 Days 17 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. Laundry

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wesley Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Johns Hopkins Hospital Records

Filed JUN 5 - 1921 ROBERT J. SLATER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1921, to June 1, 1921, that I last saw her alive on June 1, 1921, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Myomata Uteri

(duration) 7 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Post operative Intestinal Obstruction (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 24, 21

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) Leo Bloody, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Eastern Cemetery — DATE OF BURIAL: June 5 '21

20 UNDERTAKER: Fire Gods Home — ADDRESS: 406 W Lanvale St

CAUSE OF DEATH. See instructions on back. TION is very important.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Myomectomy. Double oophorectomy. Chr. salpingitis. No history of gonococcus infection. No history of salvarsan.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54272

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 D 54272

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Greenberg (Saramong)

(a) RESIDENCE. NO. 205 S. Collington ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath

PARENTS

10 NAME OF FATHER ~~Jacob Greenberg~~ Ziatha Saramong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bath

12 MAIDEN NAME OF MOTHER Anna Lesiman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bath

14 Informant (Address) Jacob Greenberg 205 S Collington

15 Filed JUN 5 - 1921 ROBERT E. LAWLOR Registrar

Burial Permit Clerk

CAUSE OF DEATH. See instructions on back. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1921

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1921, to June 4, 1921, that I last saw h[illegible] alive on June 4, 1921, and that death occurred, on the date stated above, at 12.35 a m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

(duration) yrs. mes. 1 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 8hrs ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine findings

(Signed) L. Greenberg M. D.

June 4, 1921 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 6 1921
20 UNDERTAKER	ADDRESS
Wendell Dippel Sons	378 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

54273

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 54273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 N Paterson Park ave WARD 8)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Schnitzlein

(a) RESIDENCE. No. 1611 N Paterson Park ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Schnitzlein

6 DATE OF BIRTH (month, day, and year) June 21 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Store

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Leonhardt Schnitzlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cathrine Kaiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Schnitzlein

(Address) 1611 N Paterson Park ave

ROBERT J. KRAUTER

15 Filed JUN 5 1921 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1921

17 I HEREBY CERTIFY, That I attended deceased from June. 3 1921, to June 3 1921, that I last saw h alive on June 3 1921, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Penis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Uraemia Coma.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec. 10. 21

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Barry M. Joffe, M. D.

Dec 5. 1921 (Address) 2028 E. Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	June 1921
20 UNDERTAKER	ADDRESS
Wendell Diffel & Son	378 Mnn

CAUSE OF DEATH must be filled in. See instructions on back. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54274 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 79 D 54274

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View 17 WARD)

2-FULL NAME John Powelson

(a) RESIDENCE. NO. 2119 Huntington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10 NAME OF FATHER John Powelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Elizabeth Springer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Missouri

14 *Informant (Address) Hospital Records, New City Hospital.

15 Filed JUN 5 - 1921 Burial Permit Issued Registrar

CAUSE OF DEATH. See instructions on back. ATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 28, 1921, to June 3, 1921, that I last saw h... alive on June 3, 1921, and that death occurred, on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic insufficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) B. Herman, M. D.

6-4-21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	June 7, 19
20 UNDERTAKER	ADDRESS
Edw. Woodyard	Govans

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54275

CERTIFICATE OF DEATH.

79 333 D 54275

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 E Lafayette St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leo McNicholas

(Residence in Baltimore: No. 323 E Lafayette Ave St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. (Month) 14 (Day), 1888 (Year)

7-AGE, 32 yrs. 8 mos. 19 ds.

If LESS than 1 day. ....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Labor
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William McNicholas

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Rice

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary McNicholas

(Address) 323 E Lafayette Ave

15- JUN 5 - 1921 1921 BOARD OF HEALTH Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25th 1921, to June 2nd 1921, that I saw h(im) alive on June 1st 1921, and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart
(Mitral Regurgitant)
(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Indigestion & Nervous Exciteme
(Duration) yrs. mos. 1 ds.

(Signed) J. Kallaway M. D.

June 2, 1921 (Address) 318 E Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, June 6, 1921

20-UNDERTAKER E. A. Wedefind — ADDRESS 601 E 32 St

Important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54276

CERTIFICATE OF DEATH.

150

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3128 Elliot ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy K Bourke

(a) RESIDENCE. No. 3128 Elliot ST., WARD.

(If nonresident give city and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20/2

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER James Bourke

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Gegner

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant James Bourke
(Address) 3128 Elliott St

15 JUN 5 - 1921 19 Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1921

17 I HEREBY CERTIFY, That I attended deceased from June 2 1921, to June 4 1921, that I last saw h[illegible] alive on June 4 1921, and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Passive congestion
of lungs.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Kaufmann M. D.

6/7, 1921 (Address) 3435 Odonnell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL June 6 1921

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eas[illegible]

CAUSE OF DEATH to be plainly written in ink. See instructions on back of certificate. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* or "Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Premature birth.
Probably congenital
malformation of heart.
No pneumonia. Congestion
due to heart condition.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 D 54277

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 4th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Fendrick

(a) RESIDENCE. NO. 124 Augusta Ave ST., ... WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 4, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 1 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Eugene Fendrick

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary C. Gaylon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Maria Fendrick
(Address) 124 Augusta Ave

15 Filed JUN 5 - 1921 ... Registrar

CAUSE OF DEATH must be given. Every question must be answered. Physician's or coroner's certificate must be filed with the Registrar of Vital Statistics before a burial permit will be issued. Please read carefully the instructions on back of certificate. ATTENTION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1921

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1921 to June 4, 1921, that I last saw him alive on June 4, 1921 and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatarum
Livida

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Torsion of umbilical cord (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Thos K Galvin M. D.

, 19 (Address) 23 St. Paul Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 6 1921

20 UNDERTAKER F. A. Krause & Son

ADDRESS 703 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54278

CERTIFICATE OF DEATH.

X 40 D 54278

REGISTERED NO.....

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. ..... ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rose D Boudreaux

(a) RESIDENCE. NO. Spray N.C. ST., ... WARD. Spray N.C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Mr John Boudreaux

6 DATE OF BIRTH (month, day, and year) Jan-25-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Stultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dolly Gregory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs H P Cowan

(Address) Spray N. C.

15 Filed JUN 5 - 1921 19 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1921

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1921, to June 3, 1921, that I last saw h.r alive on June 3, 1921, and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Carcinoma of Stomach

o (duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Suppurative Parotitis, left (duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of May 30, 1921

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. H. Noble, M. D.

, 19 (Address) Church Home Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Spray N C

DATE OF BURIAL 6/5 1921

20 UNDERTAKER H E Myhel

ADDRESS 1924 Broadway

CAUSE OF DEATH IS very important. See instructions on back

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54279

CERTIFICATE OF DEATH.

69 D 54279

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1200 Dellwood Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Poole Kingsbury

(Residence in Baltimore: No. 1200 Dellwood Ave.) St. 36 yrs., 10 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 14 (Day), 1884 (Year)

7-AGE, 36 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE (State or Country), Baltimore Md.

PARENTS:

10-NAME OF FATHER Elias T. Kingsbury

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Amanda E. Younker

13-BIRTHPLACE OF MOTHER (State or Country), York Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt. M. Kingsbury

(Address) 1200 Dellwood Ave.

15- FILED JUN 5 - 1921 ENTERED Issued Burial Permit Clerk Registrar.

CAUSE OF DEATH (Please read carefully and answer in full all questions for which there is space. Every item is important. See instructions on back of certificate.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrage following Convulsions

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) John Chatham M. D. (Coroner.)

June 7 1921 (Address) 1632 Rolandene

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Mary's (Hampden)

DATE OF BURIAL, June 6. 1921

26-UNDERTAKER Horace H. Burgee

ADDRESS 3631 Falls Rd.

Spec.—1-10-21—M&T—1500 Bks.

D 54280

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54280

CERTIFICATE OF DEATH.

120

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 341 S. Chester ST., 2 WARD)

2-FULL NAME Ellen Thelen

(a) RESIDENCE NO. 341 S. Chester ST., 2 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Thelen

6 DATE OF BIRTH (month, day, and year): July 15 1864

7 AGE: Years 56; Months 10; Days ; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10 NAME OF FATHER: Michael Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ire.

12 MAIDEN NAME OF MOTHER: Elizabeth Boylan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ire.

14 Informant: Mary Walsh (Address) 341 S. Chester St.

15 Filed JUN 5 - 1921 19.... Burial or Removal Permit Issued

CAUSE OF DEATH. If place of death is unknown, see instructions on back of Certificate. INFORMATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-3-1921

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1921, to June 3, 1921, that I last saw h[illegible] alive on June 3, 1921, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemic Convulsion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination of Body

(Signed) Geo. Keller M. D.

6-5 1921 (Address) 1937 Wright St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: 6-6 1921

20 UNDERTAKER: J. A. Moran ADDRESS 3000 E Balto St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54281

CERTIFICATE OF DEATH.

120 D 54281

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3628 Park Heights Ave ST. 15 WARD)

2-FULL NAME Christina Schmidt

(a) RESIDENCE. No. 3628 Park Heights Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 3 mos. — ds. How long in U. S., if of foreign birth? 56 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernhardt J. Schmidt

6 DATE OF BIRTH (month, day, and year) Sept 24th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant William F. Wahl

(Address) 3628 Park Heights Ave

15 FILED JUN 5 - 1921 ROBERT J. KRAUTER Registrar Burial Permit Clerk

TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to June 2nd, 1921, that I last saw her alive on June 1st, 1921, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) [illegible], M. D.

6/8, 1921 (Address) 517 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	June 6 1921

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

R

HEALTH DEPARTMENT—CITY OF BALTIMORE D 54282

CERTIFICATE OF DEATH.

D 54282 6 X 79

1-PLACE OF DEATH Womans Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Lafayette Court Johns ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Rubenstein

(Residence in Baltimore: No. 1802 E Baltimore St.; ....yrs. 2 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, June (Month) 23 (Day), 1877 (Year)

7-AGE, 49 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Macon Georgia

PARENTS.

10-NAME OF FATHER, Benjamin Skalowske

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ideal Skalowski

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M Rubenstein

(Address) New Orleans La

15- JUN 5 - 1921 ROBERT J. KRAUTER

Filed ....., 191... Registrar.

important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 28 1921, to June 5 1921, that I saw her alive on June 5 1921, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis MOR
Mitral Insufficiency

(Duration) 4 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Toxic vomiting

(Duration) ....yrs. 5 mos. ....ds.

(Signed) Frank C Walker M. D.

June 5, 1921. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 7 ds. In the State ....yrs. 9 mos. ....ds.

Where was disease contracted, if not at place of death? 7

Former or usual residence New Orleans, La.

19-PLACE OF BURIAL OR REMOVAL, Ohel Shalom DATE OF BURIAL, June 7, 1921

20-UNDERTAKER Harold Goodstein ADDRESS 1100 McCulloh St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54283

CERTIFICATE OF DEATH.

54 D 54283 REGISTERED NO. C

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. Lafayette Ave & John ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Auguste Sonneborn

(Residence in Baltimore: No. 2343 Eutaw Place) (If not in Baltimore, give usual residence.) Aft 35 (If LESS than 1 day, yrs. 9 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, August (Month) 5 (Day), 1845 (Year)

7-AGE, 75 yrs. 9 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Breitenbach Germany

PARENTS.

10-NAME OF FATHER. Levy Sonneborn

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Amalia Sonneborn

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Sonneborn Jr.

(Address) 2343 Eutaw Place

15- JUN 5 - 1921 Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4 1921, to June 4 1921, that I saw her alive on June 4 1921, and that death occurred, on the date stated above, at 9:25 A m.

The CAUSE OF DEATH* was as follows:

Pernicious anaemia

(Duration) 1 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Frank Delatheinslon M. D.

June 4, 1921. (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. mos. ds. In the State 31 yrs. mos. ds.

Where was disease contracted, if not at place of death? Bethany

Former or usual residence 2343 Eutaw Place.

19-PLACE OF BURIAL OR REMOVAL, Chet Shalom DATE OF BURIAL, June 6, 1921

20-UNDERTAKER David Sondheim ADDRESS 1824 W Lexington

DW

important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54284

CERTIFICATE OF DEATH.

151

D 54284

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 E. Lafayette ave. WARD 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Premature Birth Infant Todd

(a) RESIDENCE. No. 409 E. Lafayette ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/4/21

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Bernard A Todd

11 BIRTHPLACE OF FATHER (city or town) Smithsburg
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary V. Barnhart

13 BIRTHPLACE OF MOTHER (city or town) Hanover
(State or country) Penna.

14 Informant Bernard A. Todd.
(Address) 419 E. Lafayette.

15 Filed JUN 5 - 1921 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5 1921

17 I HEREBY CERTIFY, That I attended deceased from 6/4, 1921, to 6/5, 1921, that I last saw h[illegible] alive on June 4, 1921, and that death occurred, on the date stated above, at 3:30 a, m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(6 mo. duration)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal (Cardiac + Hypertrophy enlargement) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dein Francini, M. D.

6, 1921 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hanover Penn	June 5 1921
20 UNDERTAKER	ADDRESS
Geo Lenhard & Son	607 W Pratt

CAUSE OF DEATH. See instructions on reverse side. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 54285 HEALTH DEPARTMENT—CITY OF BALTIMORE D 54285

CERTIFICATE OF DEATH. X 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Maryland ave ST.; V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Hall

(a) RESIDENCE. NO. 1715 Maryland ave ST., WARD. Annapolis Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Hall

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 60 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 63

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Annapolis Md

PARENTS

10 NAME OF FATHER: Benjamin Goodrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md

12 MAIDEN NAME OF MOTHER: Charlotte Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Annapolis

14 Informant: Thomas Hall

(Address) 1715 Maryland Ave

SCHEDULE A RETURNED

15 Date Received: JUN 6 - 1921 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/5/ 1921

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1921, to June 5, 1921

that I last saw h Ev alive on June 4, 1921

and that death occurred, on the date stated above, at 2:40 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Interstitial nephritis

(duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Johnpierre M. D.

19 (Address) 1019 Duke of Gloucester

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury from Annapolis — DATE OF BURIAL: July 6 1921

20 UNDERTAKER: Kenn H. Crouse & Son — ADDRESS: 1400 Mosher

CAUSE OF DEATH ... TION is very important. See instructions on back of ...

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54286

CERTIFICATE OF DEATH.

9 D 54286

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 W Lafayette av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roger B. Burke

(Residence in Baltimore: No. 1020 W Lafayette av St.: 2 yrs., 6 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 9 (Day), 1917 (Year)

7-AGE, 3 yrs. 11 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... 000 .....

9-BIRTHPLACE, (State or Country), Port Henry N.Y.

PARENTS.

10-NAME OF FATHER, David A Burke

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Idaid Bateman

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David A. Burke

(Address) 1020 W. Lafayette ave

15- Filed JUN 6 - 1921 191.... ROBERT J. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 5 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 — 1921, to June 5 — 1921, that I saw h m alive on June 5 — 1921, and that death occurred, on the date stated above, at 3.10 m.

The CAUSE OF DEATH* was as follows:

Lamp of Diphtheria

about 5 or 6 days

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Probably Cardiac paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Charles M. Cook M. D.

June 6, 1921. (Address) 1107 W Lanvale st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Port Henry N.Y. DATE OF BURIAL, June 8, 1921

20-UNDERTAKER Gen. Wm. Burt Son ADDRESS 2503 Edmondson ave

Important. See instructions on back of Certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54287

CERTIFICATE OF DEATH.

104 D 54287

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 151 W. Hamburg ST.: 23 WARD)

2-FULL NAME Marvin E. Robinson

(a) RESIDENCE. NO. 151 W. Hamburg ST. 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	Col	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/25/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Clarence Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Edith Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edith Gross
(Address) 151 W. Hamburg St

15 Filed JUN 6-1921 ROBERT J. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/21

17 I HEREBY CERTIFY, That I attended deceased from 6/3/21 to 6/5/21

that I last saw h... alive on 6/5/21

and that death occurred, on the date stated above, at 12:20 P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Gunboorey, M. D.

6/5/21 (Address) 908 S. Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	June 6. 1921
20 UNDERTAKER	ADDRESS
L. E. Bromwell Son	108 N. Howard

INSTRUCTION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54288 ✓ D 54288

CERTIFICATE OF DEATH.

REGISTERED NO. C 40

D 54288

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3028 Brighton ST.; 16 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out 17. 18.)

2-FULL NAME John F. Wolfe

(Residence in Baltimore: No. 3028 Brighton Pl ST.; 4th yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 28 (Month) (Day), 1850 (Year)

7-AGE, 70 yrs. 8 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Commissions 045
(b) General nature of industry, business, or estsblishment in which employed (or employer): Wholesale

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John H. Wolfe

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Agnes R. Fadley

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate B. Wolfe

(Address) 3028 Brighton Pl

15- JUN 6 - 1921 Filed....., 191. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 4 (Day), 1921 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 8, 1919, to June 4 1921, that I saw h[illegible] alive on June 3 1921, and that death occurred, on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage (bowel)

(Duration) yrs. mos. 2 ds.

(Signed) Wm A. Fitzhugh M. D.

June 4, 1921 (Address) 1020 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, June 6, 1921

20-UNDERTAKER John O'Mitchell ADDRESS 1901 W. Fayette

important. See instructions on back of certificate

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 54289

D 54289

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, Bay View ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward T. Mullikin

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Richard Mullikin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Alta Ogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records, New City Hospital

15 Filed JUN 6 - 1921 Registrar

ROBERT J. KRUTZE
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1921

17 I HEREBY CERTIFY, That I attended deceased from February 7, 1921, to June 3, 1921

that I last saw him alive on June 2, 1921

and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) B. Eisenman, M. D.

6/3/21 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL 6-6-21

20 UNDERTAKER William Cook — ADDRESS 502 E Nott Av

CAUSE OF DEATH must be given. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54290

120-091

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Morrow.

(a) RESIDENCE. No. 2634 Francis St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Daniel Morrow

6 DATE OF BIRTH (month, day, and year) Dec. 20 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mississippi

PARENTS

10 NAME OF FATHER Thomas Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mississippi

12 MAIDEN NAME OF MOTHER Hannah Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mississippi

14 Informant Myrtle Morrow (Address) 1831 W. Mosher Street

15 Filed JUN 6 - 1921 16 ROBERT J. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1921, to June 5, 1921, that I last saw h[illegible] alive on June 4, 1921, and that death occurred, on the date stated above, at 2.20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Broncho Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No. Date of

Was there an autopsy? No. Clinical & Laboratory

What test confirmed diagnosis?

(Signed) Fred J. Bamfield, M. D.

1921 (Address) Maryland General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL June 7 1921

20 UNDERTAKER Wm Cook ADDRESS 5026 E. Monument

CAUSE OF DEATH in plain [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54291

CERTIFICATE OF DEATH.

120 D 54291

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1224 Jefferson ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Dodson

(a) RESIDENCE. NO. 1224 Jefferson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Dodson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Suffolk Virg

PARENTS

10 NAME OF FATHER Josiah A Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER Caroline Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Geo L Stanley

(Address) 1224 Jefferson St

15 FILED JUN 6 1921 (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1921

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1921, to June 4, 1921, that I last saw h[illegible] alive on June 3, 1921, and that death occurred, on the date stated above, at 6 9, m.

The CAUSE OF DEATH was as follows:

Interstitial nephritis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) W. A. Robinson M. D.

19 (Address) 520 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Jun 6 1921
20 UNDERTAKER Chas G Bailey	ADDRESS 1417 Jefferson

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54292

CERTIFICATE OF DEATH.

79 D 54292

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Ramsey ST.: 19 WARD)

2-FULL NAME Daniel McSweeney

(a) RESIDENCE. No. 1521 Ramsey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) May 17, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 940

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer BORK

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Edw. McSweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dut Kinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Daniel McSweeney

(Address) 1521 Ramsay st

15 Filed JUN 6 1921 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1921

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1921, to June 4, 1921, that I last saw him alive on June 4, 1921, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Brights

(duration) yrs. 24 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) M. O'Neill M. D.

6/5, 1921 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	June 7 1921

20 UNDERTAKER John J. Fields ADDRESS 1200 W Lombard

CAUSE OF DEATH. See instructions on back TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54293

CERTIFICATE OF DEATH.

28 D 54293

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 711 Light Street. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Kearns.

(Residence in Baltimore: No. 711 Light Street.

48 ----------.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, Do not know., 1 .....
(Month) (Day) (Year)

7-AGE, 48 yrs. --- mos. --- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Do not know..

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elbert L. Holland.

(Address) 711 Light Street.

15- Filed JUN 6-1921, 191... ROBERT I. KRAUTER Burial Permit Clerk Registrar.

CAUSE OF DEATH to be plainly written. Every question must be answered if possible. Omissions will cause delay. Physicians are requested to state the cause of death in such terms as will indicate the disease, and not the symptoms alone. Indefinite terms, such as "fever," "debility," "weakness," "old age," "consumption," "dropsy," "convulsions," "paralysis," "cancer," "tumor," "inflammation," "abscess," "hemorrhage," "ulcer," "child-bed," "accident," "suddenly," "found dead," are not sufficient. Deaths from violence must state the means of injury, and whether accidental, suicidal, or homicidal. Deaths during child-bed must mention the day and hour after confinement. Deaths of infants must state whether the child was born alive, and how long it lived. Deaths from contagious diseases must be reported immediately. Physicians are requested to make their returns daily. Blanks will be furnished on application. Penalty for neglect, $5.00. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3rd, 1921., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Otto A. Eminhizer M. D.
(Coroner)

June 5th, 1921. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	June 6, 1921.

20-UNDERTAKER	ADDRESS
John J. Fidd	1200 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 54294

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 54294

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1302 McCulloh Street. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Louisa Westcott Hill

(a) RESIDENCE. NO. 1302 McCulloh Street ST., 11 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 82 yrs. 8 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas Hill

6 DATE OF BIRTH (month, day, and year) October-3-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

000

9 BIRTHPLACE (city or town) Chestertown,
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Geo. B. Westcott

11 BIRTHPLACE OF FATHER (city or town) Bridgeton
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Mary A. Hynson

13 BIRTHPLACE OF MOTHER (city or town) Millington
(State or country) Maryland

14 Informant Malcolm W. Hill, (son)
(Address) 246-W-Lanvale-St. City.

15 Filed JUN 6 - 1921 ROBERT A. LANDIS Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3d 1921

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1921, to June 3d 1921, that I last saw h alive on June 2nd 1921, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valv. Endocarditis,

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema (Pulmonary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jefferson Brand M. D.

6/4 1921 (Address) 2844 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	June-6-21

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH. See back of certificate. TION is very important. See instructions on back

D 54295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 D 54295

1-PLACE OF DEATH Western Maryland R.R. Yard. REGISTERED No. C

CITY OF BALTIMORE (No. Port Covington. St.: 23rd WARD)

2-FULL NAME John C. Millenburg.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 134 W. Clement St. St.; yrs. 25 mos. ------ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, January 12th, 1894., 1 (Month) (Day) (Year)

7-AGE, 27 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): W. Md. R.R. Co.

9-BIRTHPLACE, (State or Country). Queen Anne Co. Md.

PARENTS.

10-NAME OF FATHER, Thomas C. Millenburg.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Mary Livingston.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Millenburg. (mother).

(Address) 111 W. Mc Comas Street.

15- JUN 6 - 1921 ROBERT P. KRAUTH
Filed....., 191.... Burial Permit Registrar.

CAUSE OF DEATH to be plainly written. Every question must be answered if possible. Unknown or doubtful answers are important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4th, 1921., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally crushed about the head
between a crane and a car.

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. Pentland M. D.

June 5th, 21. (Coroner.) 1017 S. Charles Street
....., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cem	6/6, 1921
20-UNDERTAKER	ADDRESS
J. Frew McCully	130 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 54296

D 54296

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Cox ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard J. Stallings

(a) RESIDENCE. NO. 1209 Cox ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 2-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt md
(State or country)

PARENTS

10 NAME OF FATHER Emil Stallings

11 BIRTHPLACE OF FATHER (city or town) Balt md.
(State or country)

12 MAIDEN NAME OF MOTHER Elvetta Videhamer

13 BIRTHPLACE OF MOTHER (city or town) Balt Co
(State or country)

14 Informant Emil Stallings
(Address) 3701 Roland Ave

15 FILED JUN 6 - 1921 ROBERT A KRAUER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5. 1921

17

I HEREBY CERTIFY, That I attended deceased from Mar. 2, 1921 to June 4, 1921,
that I last saw h.. alive on June 4 1921,
and that death occurred, on the date stated above, at 11 30 p m.

The CAUSE OF DEATH* was as follows:

Oedema of brain

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lymphatic Drainage.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Bulging of membranes

(Signed) C. F Coughlin M. D.

6/5, 1921 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 6 1921

20 UNDERTAKER R S Marshall ADDRESS 3539 Fall Rd

TION is very important. See instructions on

COVELL

Spec.—8-24-14—M. & T.—2000 Bks.

D 54297

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54297

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1746 Mulliken ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Covell

(Residence in Baltimore: No. 1746 Mulliken St. St. 56 yrs. ..... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ... (Month) January (Day) 1 (Year) .....

7-AGE, 36 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, John Covell

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Regina Burman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myrtle Henry

(Address) 1502 Mulliken St

15- ROBERT J. BRASTED JUN 6 - 1921

Filed ..... 191 ..... Registrar.

Burial Permit Issued

Cross out words not important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 3 1921, that I saw h.... alive on June 3 1921, and that death occurred, on the date stated above, at 10:45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 Month yrs. ..... mos. ..... da.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) Richard Gaither M. D.

June 3, 1921 (Address) 1502 Mulliken

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, June 6, 1921

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 54298

D 54298

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 209 S. Paca ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh. J. Green

(a) RESIDENCE. NO. 209 S. Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced (write the~~ word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	c	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Hugh Green Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E. Green
(Address) 209 S. Paca

ROBT. J. BRADY
Filed ..... 19 Registrar

Burial Permit Issued JUN 6 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1921

17 I HEREBY CERTIFY, that I attended deceased from June 1, 1921, to June 5, 1921, that I last saw h... alive on June 5, 1921, and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Boyd, M. D.

19 (Address) 612 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cemy	June 8 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2178 Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations should not be used. Indefinite terms, such as "Debility," "Old Age," "Paralysis," "Tumor," "Cancer," "Consumption," "Fever," "Heart Disease," "Kidney Disease," "Liver Disease," "Lung Disease," "Stomach Disease," "Stroke," "Tuberculosis," "Ulcer," "Unknown," "Unspecified," "Unspecified Cause," "Unspecified Disease," "Unspecified Illness," "Unspecified Injury," "Unspecified Poisoning," "Unspecified Trauma," "Unspecified Wound," "Unspecified Wounds," "Unspecified Wounds and Injuries," "Unspecified Wounds and Injuries and Poisoning," "Unspecified Wounds and Injuries and Poisoning and Trauma," "Unspecified Wounds and Injuries and Poisoning and Trauma and Wounds," "Unspecified Wounds and Injuries and Poisoning and Trauma and Wounds and Injuries," "Unspecified Wounds and Injuries and Poisoning and Trauma and Wounds and Injuries and Poisoning," "Unspecified Wounds and Injuries and Poisoning and Trauma and Wounds and Injuries and Poisoning and Trauma," "Unspecified Wounds and Injuries and Poisoning and Trauma and 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D 54299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D 54299

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2749 W. Nathan ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Gourley

(Residence in Baltimore: No. 2749 W. Nathan ST.; 50 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, October 21, 1846
(Month) (Day) (Year)

7-AGE 74 yrs. 7 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Isaac Brown

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Susan Hall

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. H. Fetzing

(Address) 2749 W. Nathan ave

15-

Filed ..... 191 JUN 8 - 1921 Registrar.

Burial Permit Oliver

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4, 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said jury
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (5 minutes)
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Heuisler M. D.
(Coroner.)

June 4 1921 (Address) 2882 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Leadenhall Park Cem. DATE OF BURIAL, June 7 1921

20-UNDERTAKER Jos. Sueerdens & Son ADDRESS 217 S. Broad

Check for important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 54300

CERTIFICATE OF DEATH.

D 54300

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1221 Ostend st ST.: 21 WARD)

2-FULL NAME Emma. A. F. Anet

(a) RESIDENCE. NO. 1221 Ostend st ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~ (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William. H. Anet

6 DATE OF BIRTH (month, day, and year) April 22 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None of 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Francis Schaffis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant William. H. Anet

(Address) 1221 Ostend st

15 Filed 19 Registrar JUN 6 - 1921

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1921

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to June 4, 1921, that I last saw h~~im~~ alive on June 4, 1921, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Pulmonary TB

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen D Davis M. D.

19 (Address) 1327 Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemy	June 8 1921
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2178 Bway

mation should be entered, if known, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2009 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 54301

CERTIFICATE OF DEATH.

1810

D 54301

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N. Saratoga ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry F Vogel

(Residence in Baltimore: No. 817 N. Saratoga St.; 66 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Feb (Month) 9 (Day), 1855 (Year).

7-AGE, 66 yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wiegand Vogel

11-BIRTHPLACE OF FATHER (State or Country), Germy

12-MAIDEN NAME OF MOTHER Pauline Zimerling

13-BIRTHPLACE OF MOTHER (State or Country), Germy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wiegand Vogel

(Address) 817 N. Saratoga St.

15-

JUN 6-1921 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 3 (Day), 1921 (Year).

17- I HEREBY CERTIFY, That I attended deceased from March 31 1921, to June 3 1921, that I saw h[illegible] alive on June 3 1921, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

.....Cerebral Hemorrhage.....

.....

.....

..... (Duration) .....yrs. mos. 66 ds.

CONTRIBUTORY (Secondary) None

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Leonard E Krauss M. D.

June 6 1921. (Address) 2324 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park Cem	June 6 1921

20-UNDERTAKER Jos Joerdens Son ADDRESS 217 S. Pac

N.B.—Every item of information should be given, so that it may be properly entered in the CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 9th DAY December

OF 1964 THE MICROPHOTOGRAPHS APPEARING

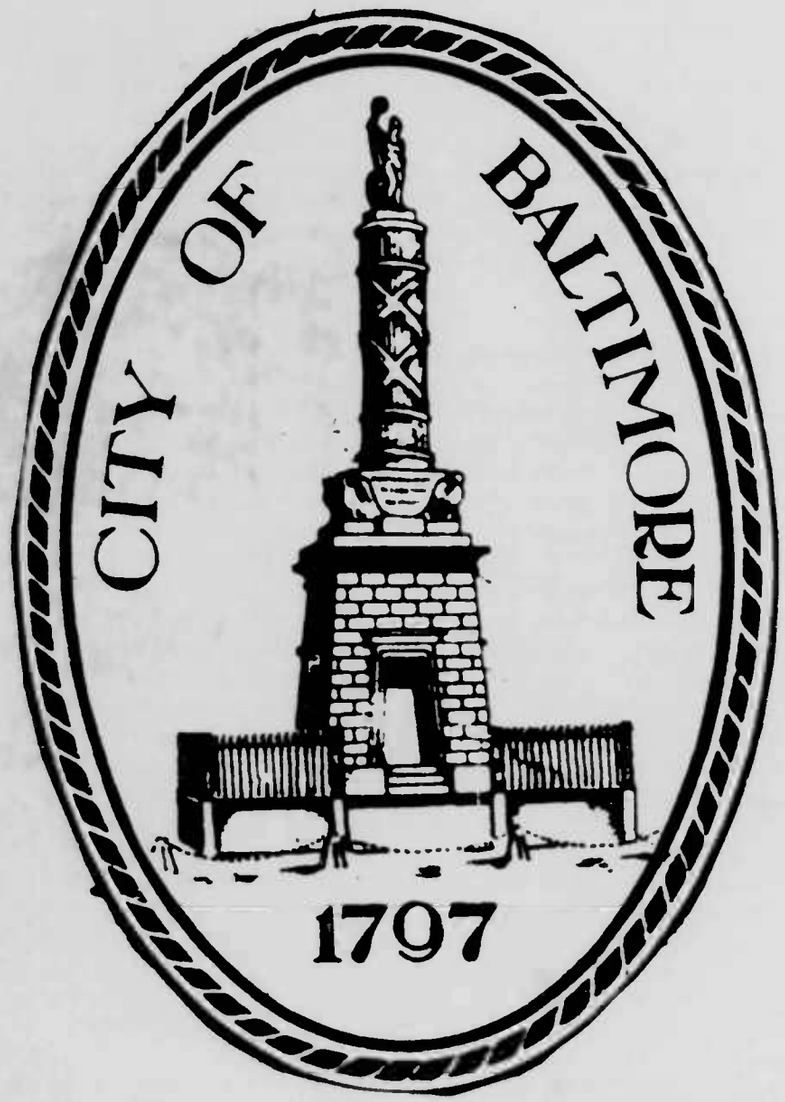
HEREIN STARTING WITH #D 51019 February 19, 1921 AND

ENDING WITH #D 54301- June 6, 1921 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health

BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: D. McFaul



END OF REEL